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Chemist&Druggist
The Newsweekly for Pharmacy

C&D

7 June 2003

Stormy SGM sends Council clear message

Appliance contractors' pay review proposal

Pan-European pricing could kill off PIs

Inside an award-winning shop redesign

For family allergies, Piriton® has it covered

From hayfever to allergic dermatitis, Piriton has the answer. It provides fast symptom relief and the range has a formulation to suit family members from 1 year up. With almost 50 years of experience, you know you can trust Piriton.

PIRITON®
chlorpheniramine maleate

For family allergies

Piriton Allergy Tablets and Piriton Syrup Product Information: **Presentations:** Piriton Allergy Tablets containing 4mg chlorpheniramine maleate. Piriton Syrup containing 4mg chlorpheniramine maleate in 10ml. **Uses:** Symptomatic relief of allergic conditions including hayfever. **Dosage and administration:** Tablets: *Adults:* 1 tablet Every 4-6 hours. *Children aged 6-12.* 1/2 tablet. Every 4-6 hours. Syrup: *Adults* 10ml. Every 4-6 hours. *Children aged 6-12:* 5ml. Every 4-6 hours. *Children aged 2-6.* 2.5ml Every 4-6 hours. *Children aged 1-2:* 2.5ml, twice daily. **Contraindications:** Hypersensitivity. Concurrent or recent treatment with MAOIs. **Precautions:** May increase effects of alcohol. May affect ability to drive and use machinery. **Co-existing conditions:** Use with caution in prostate, respiratory, liver, cardiovascular and thyroid disease; epilepsy, glaucoma and other eye conditions. Syrup contains sugar, use with caution in diabetes. Maintain good dental hygiene. **Pregnancy and lactation:** Consult doctor before use. **Side effects:** Sedation. Less commonly gastrointestinal disturbances, blurred vision, headaches, urinary retention, dry mouth, muscular incoordination, jaundice, cardiovascular disturbances, chest tightness, dizziness, blood dyscrasias, allergic reactions and tinnitus. Children and the elderly are more prone to the neurological anticholinergic effects and rarely may become confused or excitable. **Retail selling price:** Piriton Allergy Tablets 30: £2.85; Piriton Syrup 150ml £3.79. **Legal category:** P. **Product licence numbers:** 0036/0088 (Piriton Syrup). 0036/0091 (Piriton Allergy Tablets). **Product licence holder:** Stafford-Miller Limited, Welwyn Garden City, AL7 3SP. Further information is available from Medical and Consumer Affairs, GlaxoSmithKline Consumer Healthcare, Brentford, Middlesex TW8 9GS, U.K. **Date of revision:** December 2001. PIRITON and the ALLERGY ANSWERS logo are trademarks of the GlaxoSmithKline group of companies.

www.dotpharmacy.com

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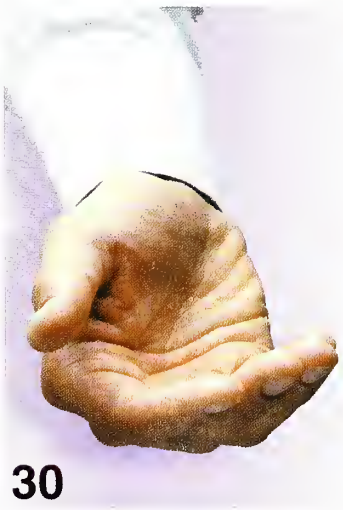
This week

Pharmacy update

Regulars



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Features

PROFESSION

SGM demands a radical rethink

Pharmacists have sent a strong message to the Royal Pharmaceutical Society's Council that they are not happy with the Society's modernisation agenda.

At a sometimes stormy special general meeting of between 330 and 500 pharmacists in London last Sunday, both the way in which the process was being carried out and the direction it is heading were criticised. Four motions were carried and another was 'laid on the table' for future consideration by Council.

During the three hours of debate in which the president, Marshall Davies, encouraged as many people as possible to give their views, only five spoke from the floor in favour of the Society's actions to date, and three of these were current Council members.

Much of the debate centred on the notion that the Society had not given equal consideration to the possible structures it could have in becoming a 'modern regulator' in line with the recommendations of the Kennedy Report.

As a result, the SGM supported a call for the Society to develop a two-board system, where a board with a high number of lay members would look after the regulation of the profession, while another, with a smaller proportion of lay members, would continue to promote professional activities and represent the profession.

Among the concerns were:

- that the Society was moving inexorably towards becoming a regulatory body while giving up any professional representation powers;
- that the Society's unelected administration team seemed to be steering the Society in this direction rather than listening to and acting on behalf of the members' views;
- that only one possible model for the future had been considered in depth and only one legal opinion sought;
- that the Society has been too keen to accept the Government's requirements rather than preparing to challenge them;
- that the draft new Charter had been issued without the full Council's approval; and
- that this draft Charter did not include in its objects wording along the lines that the Society should promote the professional interest of the Society.

The first motion, which took the best part of two hours to debate, was proposed by newly elected Council member Nicholas Wood. He moved that the Society should abandon its current proposals for modernisation and develop instead a model of two boards, one for regulation and one for professional representation and development.

The second called for any new Charter to retain, without qualification, the object "to maintain the honour and promote and safeguard the interests of members in their exercise of the profession of pharmacy".

The third instructed the Society's Council to arrange for a referendum of the entire membership to establish the level of support for any proposed new Charter once the details of any such proposal(s) have been finalised.

A fourth, held without any additional debate due to time constraints, said that the Council should hold a referendum among the membership to establish the level of support before seeking charitable status for the Society.

Coverage of the debate at the SGM is given on pages 14–15.

RPSGB

Council responds to SGM

The strength of feeling shown at the SGM prompted the Royal Pharmaceutical Society's Council into making several key decisions at its meeting on Wednesday.

These include:

- acknowledging members' concerns which were raised at the SGM
- a decision to not progress the pursuit of charitable status for the Society for the present
- acknowledging the professions' strong support for the Object in the current Charter that states: "To maintain the honour and safeguard and promote the interests of the members"
- to take these concerns fully into account when considering the content of the new Charter once the consultation process is complete.

Late news – new president

Council has elected Dr Gillian Hawksworth as the RPSGB's new president. Dr Hawksworth replaces Marshall Davies, who steps down after serving two years.

Alison Ewing has been elected vice-president, and Linda Stone is the Society's new treasurer.

RPSGB is 'failing pharmacists'

The Royal Pharmaceutical Society is failing to represent pharmacists' interests to government, AAH group managing director Steve Dunn said this week.

He accused the RPSGB of "abrogating its responsibility for placing pharmacy at the forefront of the Government's health [illegible]", and "focusing on [illegible]" instead of [illegible] vision. The [illegible] in Northern [illegible] shows what [illegible] he said.

"It is very necessary to have a body that regulates pharmacy, but it is equally necessary to have a body that represents the best interests of pharmacists. If the Society is not going to seize that mantle, then there needs to be a coming together of other pharmacy bodies to ensure that a strong and competent lobby is maintained at the highest levels of government," Mr Dunn said at the AAH Convention in California.

Steve Dunn: "Stress is when you wake up screaming and realise you haven't fallen asleep yet ... a good definition of what 2004 may hold for pharmacy"

There is going to be no let-up in the rate of change in the pharmacy sector, he warned, highlighting four events that "will definitely happen" in 2004:

- the two-tier contract
- a re-balancing of the generics tariff and a new method of generics remuneration
- the full scale launch of medicines management and LPS activity
- the new requirements for CPD and the two-part Pharmaceutical Register.

"Each one of these individually would be a seismic shock in any system but pharmacy is going to have to endure all four in the same year," he observed, also noting that the uplift in money granted to the NHS by this Government has been truly historic but community pharmacists haven't seen any of it.

Full line wholesalers are developing medicines management systems and packages to enable pharmacists to deal with service delivery changes that will be required. These and other services wholesalers provide are often taken for granted and the full line business model has come under increasing pressure from short line wholesalers.

"AAH has radically revamped its offer in the area of parallel imports and generics and is as competitive as many short liners," said Mr Dunn.

HRH The Duke of York took some good advice recently, after meeting Isle of Sheppey pharmacist Jayesh Patel at the official opening of the Sheppey Community Hospital on May 27. Mr Patel's community pharmacy, The Sheppey Hospital Pharmacy, is based inside the new, purpose-built hospital, which also houses other primary care facilities including a GP surgery. Mr Patel, pictured fourth from the left with his brother Vino (far left), along with Sheppey GPs and members of Swale PCT's professional executive committee, chatted to the Prince in the hospital courtyard about local trends in medicine usage

OFT: keep up the pressure on MPs

PSNC has placed an advert in a parliamentary magazine highlighting the value of community pharmacists in a bid to keep the campaign against the OFT's proposal to deregulate pharmacies in the spotlight.

The advert, in last week's *The House* magazine, encourages the Government to make better use of community pharmacists' skills and the services they provide to the NHS.

"It makes no sense to limit development of services provided to patients from community pharmacies [which] are convenient, accessible and are already used and valued highly by patients," says the advert.

- So far 31 MPs have presented petitions against the OFT's recommendations.

For more information:

www.PSNC.org.uk

DoH seeks changes to appliance contractor payments

The Government is to examine the way that appliance contractors are paid following concerns about whether they represent value for money.

In particular, the DoH says "concern has been expressed about certain aspects of the arrangements which a minority of contractors have exploited in a fraudulent way", in its consultation document.

Currently, appliance contractors are paid an 'on-cost' on the price of a product, at a rate which ranges from 15.8 per cent to 25 per cent depending on the number of prescriptions dispensed per premise.

In addition, unlike pharmacy, the remuneration for appliance contractors is not subject to a global sum and the NHS does not recover any discount that the contractor may receive.

Consequently, there is a "strong incentive" to divide prescriptions between dispensing premises so as to maximise income, and a significant amount of fraud has been uncovered, says the DoH.

The DoH also highlighted "agency agreements" that exist between appliance contractors and pharmacies, under which pharmacists pass prescriptions for high value items on to appliance contractors for submission to the PPA, as they are paid more for supplying the item. The subsequent payment is then split between the two parties, says the DoH.

However, in defence of the higher payment paid to appliance contractors, the DoH says it provides additional services such as home delivery, cutting flanges to fit stomy bags, telephone helplines and NHS stoma care by employing specialist nurses.

The key proposals

These include:

- establishing service standards for the supply of appliances
- abolishing on-cost and remunerating appliance contractors through fees or by applying a flat rate of "on-cost"
- introducing a global sum as a way of capping costs
- applying the same rate of discount recovery regardless of whether the product is supplied by a pharmacy or contractor, and
- amending pharmacists' and dispensing doctors' terms of service to stop "agency agreements".

According to PSNC, which will be setting up a working party to consider the DoH's proposals: "Equalising discount between appliance contractors and pharmacists removes a long-standing thorn."

Comments on the proposals, which relate to appliance contractors in England and Northern Ireland, should be sent to Appliance Contractors Review, DoH, Room 168, Richmond House, 79, Whitehall, London SW1A 2NL by August 31, 2003.

For more information:

www.doh.gov.uk/appliancecontractors

Amoxycillin recall

Alpharma Limited is recalling Amoxycillin Mixture BP 250mg per 5ml (batch number 02K078) because it has been labelled with a mixture of 125mg per 5ml and 250mg per 5ml labels.

The affected batch, manufactured by Athlone Laboratories, is packed in plastic bottles of 100ml with Cox livery, and carries the product licence number 6453/0022.

Pharmacists who have any of the affected batch should return it to wholesalers.

For more information:

Tel: 01271 311200.

SCOTLAND

Scots seek Charter assurances

Scottish pharmacists have expressed concern over the continuing existence of the Royal Pharmaceutical Society's Scottish Executive and the security of the Society's Scottish headquarters at the latest Charter roadshow.

Several speakers suggested that the existence of the Scottish Executive should be explicit in the new Charter, as it was in the current Charter, along with a mechanism to guard against the disposal of the Society's Edinburgh premises by a London-based special general meeting.

Frank Owens, Bonnybridge, said it was necessary to ensure the Scottish Executive was empowered to carry out its duties, including policy decisions affecting the profession.

Findlay Hickey, Edinburgh, supporting this view, added that the understanding of Scottish issues by an English-based Council could be seriously flawed.

Scotland's chief pharmacist Bill Scott said Scottish ministers and healthcare agencies were unlikely to engage with Lambeth on Scottish issues and emphasised the need for the Scottish Executive to act as a consultative body.

RPSGB secretary and registrar Ann Lewis explained that, as a regulatory body, the Society's powers applied throughout the country, so a measure of central control was inevitable for the foreseeable future, but she acknowledged that healthcare delivery was a devolved responsibility in Scotland and Wales and necessitated strong local input.

However, there was some suspicion that the draft Charter was a *fait accompli* and doubt as to whether any comments made by Scottish pharmacists would be incorporated.

RPSGB president Marshall Davies assured the audience that he would convey the strength of feeling on Scottish representation back to Council. While he could not guarantee that Scottish pharmacists' views would be accepted unreservedly, he was sure Council would carefully consider the points raised.

At last Wednesday's meeting in Perth, Ms Lewis cautioned against expecting every detail of the Society's operations to be explicit in the new Charter, for it was designed to be "a high level enabling document" that had to be flexible enough to deal with healthcare and governmental developments over the next 20 to 30 years.

Ann Lewis, David Thomson and Marshall Davies

SURVEY

Study finds shared prescribing common

Nearly half of all primary care organisations share a prescribing formulary with the secondary healthcare sector, according to a survey conducted by *Pharmacy Management*.

Of 220 PCOs questioned, 47 per cent said they shared a formulary with their local hospitals, with 39 per cent sharing formularies for gastrointestinal and cardiovascular areas, 36 per cent for CNS and musculo-skeletal areas, and 34 per cent for respiratory and endocrine areas.

However, *Pharmacy Management* says the use of shared formularies poses further questions, such as how the price differentiation that "commonly goes on between the cost of a drug in hospitals compared to the cost of a drug in primary care" impacts on the contracting process.

For more information:

E-mail: ted@tba-ltd.co.uk

PRACTICE

Concern over GP closures

Essex Local Pharmaceutical Committee is concerned about the increasing tendency for GP surgeries to close on Saturdays, putting pressure on pharmacists.

The LPC has written to primary care trusts, asking them to consider GP closure applications carefully and to consider other arrangements for medicines supply, such as patient group directions. So far the response has been positive, with PCTs agreeing to work more closely with GPs, says LPC secretary John Stanley.

LEGISLATION

EU keeps ad restrictions

The European Parliament has upheld restrictions on the advertising of prescription medicines by drug companies. In 2002 the European Commission suggested the drug manufacturers should be able to provide 'disease education information' to patients with Aids, asthma and diabetes, but EU health ministers have rejected the proposal.

Questiontime

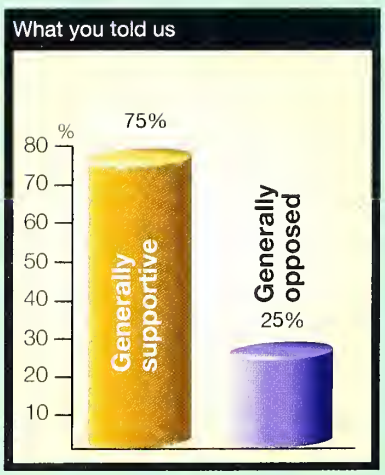
Sponsored by UniChem

Last week we asked you: "PSNC has issued proposals for a revising the control of entry regulations. Based on the outline details, are you supportive or opposed?" You replied (see right):

This week's question: Which of the options that the DoH has suggested for the way appliance contractors are remunerated do you think should be implemented?

- Retain 'on-cost' at a lower level to fund additional services
- Replace 'on-cost' with a dispensing fee and initiate a global sum and discount clawback
- Keep status quo

You can record your vote on our website: *www.dotpharmacy.com*. You have until noon on June 10 to cast your vote. We will publish the results in *C&D*, June 14.



NO, YOU'RE NOT SEEING THINGS. THE WORLD'S BIGGEST-SELLING[1] ANTIHISTAMINE NOW HAS THE BIGGEST CETIRIZINE RANGE.

Zirtek, the original cetirizine, is still the best-selling antihistamine in the world. And it still leads the way. It's the first and only cetirizine available in packs of 7, 14 and 30 tablets. And it's now also available in a child-friendly solution. But it's not just the range that's grown.

Zirtek is also about to get it's biggest ever TV and radio spend. With a mammoth advertising campaign and so much choice for your customers, shouldn't your choice antihistamine be Zirtek? And shouldn't you ensure you've enough stock to meet demand?

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RTEK ALLERGY/ZIRTEK ALLERGY RELIEF
ESENTATIONS: Film-coated tablets containing 10mg cetirizine hydrochloride. **USES:** Treatment seasonal and perennial rhinitis and chronic idiopathic urticaria. **DOSAGE AND MINISTRATION:** Adults and children aged 6 years and over: 10 mg daily. Children between o 12 years of age: either 5mg (1/2 tablet) twice daily or 10mg once daily. In renal insufficiency lve the dose to 5 mg (1/2 tablet) daily. Zirtek Allergy Relief: Adults and Children aged 12 years d over: 10mg once daily. **CONTRAINDICATIONS:** Hypersensitivity to the constituents, lactation. **TERACTIONS:** To date there are no known interactions. As with other antihistamines avoid cessive alcohol consumption. **SIDE EFFECTS:** Mild and transient drowsiness, headache, zziness, agitation, dry mouth and gastrointestinal discomfort. Convulsions have very rarely been ported. **USE IN PREGNANCY:** As with other drugs, the use of cetirizine in pregnancy should avoided. **PACKAGING/PRICE:** Zirtek Allergy: Pack of 14 tablets =£7.95 R.R.P. Pack of tablets = £14.95 R.R.P Zirtek Allergy Relief: Pack of 7 tablets= £4.45 R.R.P. **GAL CATEGORY:** Zirtek Allergy: P. Zirtek Allergy Relief: GSL. **MARKETING AUTHORISATION UMBER:** PL 08972/0032 **MARKETED BY:** UCB Pharma Limited, Watford, Herts, WD18 OUH.
RTEK ALLERGY SOLUTION
ESENTATIONS: Banana flavoured sugar-free solution containing 1mg/ml cetirizine hydrochloride **ES:** Treatment of seasonal allergic rhinitis in children aged 2 years and over, and perennial allergic rhinitis and chronic idiopathic urticaria in children aged 6 years and over. **DOSAGE AND ADMINISTRATION:** Adults and children aged 12 years and over: Two 5ml spoonfuls once daily. Children aged 6 to 11 years of age: Two 5ml spoonfuls once daily or one 5ml twice daily. Children between 2 to 5 years of age: One 5ml spoonful once daily or one 2.5ml spoonful twice daily. **CONTRAINDICATIONS:** Hypersensitivity to the Constituents, Lactation. **INTERACTIONS:** To date there are no known interactions. As with other antihistamines avoid excessive alcohol consumption. **SIDE EFFECTS:** Mild and transient drowsiness, headache, dizziness, agitation, dry mouth and gastrointestinal discomfort. Convulsions have very rarely been reported. **USE IN PREGNANCY:** As with other drugs, the use of cetirizine in pregnancy should be avoided. **PACKAGING/PRICE:** 75ml Solution = £5.99 R.R.P. **LEGAL CATEGORY:** P **MARKETING AUTHORISATION NUMBER:** PL 08972/0033 **MARKETED BY:** UCB Pharma Limited, Watford, Herts, WD18 OUH. **For further information please contact:** UCB Pharma Limited, UCB House, 3 George Street, Watford, Herts, WD18 0UH. Telephone (01923) 211811. Facsimile (01923) 229002
Date of preparation: February 2003.
UCB-ZA-03-02
References:
1. IMS HEALTH MIDAS data. Units sold from July 2001 - June 2002

ucb Pharma

ABPI justifies drug data supply

The pharmaceutical industry should not be excluded from providing product information just because it is the provider of the product, the ABPI is asserting in response to claims that doctors and drug companies are "entwined in an embrace of avarice and excess".

The critique of the global pharmaceutical industry comes in the May 31 issue of the *BMJ*. In an article, editor Richard Smith and deputy editor Kamran Abbasi maintain there is growing evidence that drug companies are influencing doctors' prescribing habits. Noting that drug companies know many "tricks" to achieve the desired result from a clinical trial, the authors say: "Doctors who have frequent contact with drug representatives are more willing to prescribe new drugs, do not like ending consultations with advice only, and are more likely to agree to prescribe a drug that is not clinically indicated.

"Patients would all benefit from greater distance between doctors and drug companies."

Responding, the ABPI cites joint research with the Postgraduate Education Department for the West of Scotland, showing commercially-sponsored education is at least as good as non-sponsored and enables expert speakers to be brought in.

It says: "To be able to prescribe them effectively, doctors need to know in detail about medicines and what they can and cannot do.

"There is no source better qualified to inform doctors and other healthcare professionals about medicines than the companies that have spent, on average, 10-12 years testing and developing them."

GP representatives have slammed the *BMJ*'s allegations, calling them "biased and two-faced".

AAH launches CPD guide

A four-section guide to continuing professional development for pharmacists has been launched by AAH Pharmaceuticals.

The guide aims to help pharmacists meet professional requirements for continued learning in their daily practice.

As well as including current information on CPD requirements the package includes a framework for assessing current knowledge and areas for improvement, a CPD planner and CPD record.

The guide is available to AAH customers for £120 and at a reduced rate for Vantage members.

Dr Mandeep Mudhar, director of marketing for AAH Pharmaceuticals, said: "The new AAHP *Guide to CPD* has been devised to help support pharmacists and encourage them to take responsibility for their own learning. This may involve pharmacists making cultural or behavioural changes to their practices but those who do embrace the concept now and work out a plan for continued learning will find that CPD can quickly become second nature."

For more information:

Tel: 02476 432346.

LPS live in Trafford North

[illegible] pharmaceutical services [illegible] the Lostock [illegible] Stretford, [illegible] and the PCT went [illegible]

[illegible] LPS the pharmacy will provide targeted domiciliary services, medicines management and medication review, health promotion, EHC, head lice and smoking cessation treatments.

Asit Raja of Lostock Pharmacy said: "Trafford North PCT have always been very supportive of community pharmacy and recognise the contribution that we can make to the health of the local population."

For more information:

E-mail: asit.raja@lostockpharmacy.freeserve.co.uk

Tel: 0161 865 1603.

PAGB PERSPECTIVE

The one-a-day debate

PAGB director Sheila Kelly considers the public's approach to a healthy diet and the need for VMS

Reduce your fat intake, keep sodium intake down, increase fibre, eat oily fish, avoid foods with added sugar – the list goes on.

The last month has seen us all bombarded with messages about healthy eating, culminating in the publication of the Food Standards Agency's recommendations on safe levels of vitamins and minerals. If you believe the headlines, vitamins and mineral tablets aren't safe and that is just what the consumer thought after a day of media coverage a couple of weeks ago. So what are we to do and what advice can pharmacists give their customers?

We are all supposed to eat at least five portions of fruit and vegetables a day. Sounds straightforward till you try. Coming from Glasgow, the heart attack capital of Britain, my normal diet is a bit vegetable light and a job which includes a lot of business lunches and dinners takes its toll. But when I attended a seminar and heard the keynote speaker predict that obesity will be the new tobacco, I realised my days of being short and cuddly may be numbered. I set out to check my diet.

I downloaded a programme which has the nutritional content of thousands of food items. What an eye-opener. The five portions can't all be from one source. Potatoes don't count because they're high in carbohydrates. Baked beans, tomato soup or anything else with added sugar also can't be counted.

Even fruit and vegetables have calories so if you try to balance this and fat intake by cutting down on dairy products you are missing out on calcium and storing up osteoporosis problems. I am lucky if I manage to eat three portions a day and that puts me in the UK average as established by the Food Standards Agency and Department of Health in the *National Diet and Nutrition Survey* published last year. It showed that young people and the elderly ate even less.

Most of us are eating no more fresh fruit and vegetables than we did when the survey was last done 15 years ago. We lead busy lives and sit-down family meals are a distant memory.

So while the five-a-day programme is a good initiative it will take time for it penetrate the national psyche. It has taken a generation to persuade us not to drink and drive and for smoking to become socially unacceptable. It's not fanciful to anticipate a similar time for the healthy eating message to take root. So what do we do in the meantime?

The Food Standards Agency report on safety, despite the headlines, set safe limits for vitamins and minerals well above the normal daily amounts but it did not address their benefits. The most up to date scientific report was published in the highly reputable *Journal of the American Medical Association* in June 2002.

JAMA concluded that in the USA, like the UK, inadequate intakes of vitamins and minerals are common among large groups of the general population and this is linked to a host of illnesses. Its conclusion is that everyone should be taking a multivitamin every day.

The majority of brands on the UK market give 100 per cent of the Recommended Daily Amount, present no safety risk and make a positive contribution to our health. PAGB's Health Supplement Information Service is working to get that message across. It would help a great deal if pharmacists did the same.

Stock up now

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New Canesten Oral is soon to appear on screens in the largest ever Canesten TV campaign.

You've heard the news, you've seen the ad, so don't miss this unmissable opportunity!

duct Information for Canesten® Fluconazole Oral Capsule. Presentation: ***Canesten®*** ***conazole Oral Capsule*** contains 150mg fluconazole. **Indications:** Treatment of candidal initis, acute or recurrent. Also for treatment of partners with associated candidal balanitis. **Lage and Administration:** *Adults (16 – 60 years)*: One capsule. **Contra-indications:** ersensitivity to fluconazole, related azole compounds or any of the excipients; co-administration terfenadine or cisapride; pregnancy and breast feeding. **Warnings and Precautions:** quate contraception necessary. A physician should be consulted if the patient or partner have had exposure to a sexually transmitted disease, or if the patient: Has had more than two infections of thrush in the last six months; is taking any medicine other than the Pill; has any disease or illness affecting the liver or kidneys or has had unexplained jaundice; suffers from any other chronic disease or illness; is uncertain of the cause of symptoms; has abnormal or irregular vaginal bleeding or a blood-stained discharge; has vulval or vaginal sores, ulcers or blisters; has lower abdominal pain or dysuria. In men, medical advice should be sought if: Sexual partner does not have thrush; they have penile sores, ulcers or blisters; there is abnormal penile discharge; penis has started to smell; dysuria. Patients should consult their doctor if symptoms have not been relieved within one week. **Side-effects:** Nausea, abdominal pain, diarrhoea and flatulence. Rarely rash, headache, hepatotoxicity and anaphylaxis. **Cost:** £12.50. **MA Number:** PL 00010/0282. **MA Holder:** Bayer plc, Consumer Care Division, Newbury, Berkshire RG14 1JA. **Legal Category:** P. **Date of Preparation:** February 2003.

Canesten® can

EUROPE

KPMG calls for single EU list pricing instead of PIs

European pharmaceutical companies should set an EU-wide price for their drugs, but with the flexibility to negotiate national contracts, professional services firm KPMG says, as part of a raft of proposed measures designed to kill the market for parallel imports.

This 'grey trade', it believes, risks irreparable damage to some of Europe's most successful companies, limits their ability to create the medicines of the future and undercuts the European Commission's stated objective to boost R&D-based pharmaceutical activities in Europe.

As well as industry abandoning the free pricing approach, KPMG believes that doctors and government remunerators in member states need to work together to strengthen their ability to negotiate prices and contracts with industry. Finally, the EU Commission itself must work to manage tangible progress on the issue.

Dr Trevor Jones: "Unfair to penalise pharmaceutical companies"

The Association of the British Pharmaceutical Industry reckons that UK pharmaceutical companies lose around £1.5 billion a year due to cheaper parallel imports. "Parallel traders make their profits from simply hawking medicines around the EU to exploit differences in prices that have been created by national governments' different healthcare policies," said Dr Trevor Jones, director-general of the ABPI.

"It is not just unfair to penalise pharmaceutical companies because of the policies of different European governments, it is positively dangerous if we are to maintain our investment in the medicines of the future. Hit our profits in this way and, as the accountancy firm has said, you hit at our ability to research new treatments," he said.

KPMG said: "By persisting with this grey goods (or parallel trade) approach, the EU and key member states are shooting themselves in the foot."

RETAILING

Boots to go store shopping on Oxford St

Boots is said to be close to signing the lease on a new flagship store on London's Oxford Street.

The new store, which is expected to replace one of five already on Oxford Street, will be located close to Bond Street Underground, according to reports in last weekend's *Independent*.

Boots is declining to comment at this stage, except to say that it is constantly looking at its store portfolio, but as yet has not signed any new lease in this prime retail location. Boots currently has over 150 stores in London.

According to Welbeck Land, the London property developer named in the deal, any announcement could be four to six weeks away

Boots is said to be in negotiations about signing the lease on a new flagship store in Oxford Street

As *C&D* went to press, Boots was planning to report its full-year 2003 results. Analysts are predicting that Boots will turn in reduced pre-tax profits of between £528 million and £640m this year, on static sales of between £5,093m and £5,875m.

Lilly brings £110m spend to the UK

American pharmaceutical manufacturer Lilly is to invest £110 million over the next five years to expand its operations in South East England.

The sum of £40m is earmarked to create a European headquarters and centre for excellence in neuroscience research at Erl Wood in Windlesham, Surrey, with 120 scientists recruited there over the next five years. Lilly also plans to invest an additional £70m in its Basingstoke operations by 2006 and increase its manufacturing capacity at Speke in the North West of England, investing another £45m over the next three years.

The South East England Development Agency's international business director, Mike Gooch, said: "We are delighted that Lilly is bringing further investment to the South East. SEEDA recognises the strategic importance of Lilly as a leading company in the knowledge-based economy which is so important, not just to Surrey and the wider South East region, but to the UK as a whole."

INDUSTRY

Minority shareholders will not stop Wella bid

Procter & Gamble is vowing to push ahead with its takeover plans for Wella, irrespective of how many shares it acquires from minority shareholders.

The initial tender offer for Wella shares, which closed at the end of May, yielded just under 10 per cent of the German haircare company's share capital. Together with the share capital already pledged, this gives P&G a 60 per cent ownership of the total issued share capital.

Under German law, the tender offer, for £66.20 per Wella voting share and £46.65 per preference share, has to stay open until June 20. P&G needs 95 per cent of the listed capital to squeeze out the remaining minority shareholders.

However, the initial deal with majority shareholders in mid-March gave P&G more than three quarters of the votes required to control the firm. As P&G chief financial officer Clayton Daley said: "While we would like to acquire as many shares as possible, we are under no obligation to do so. P&G does not need a domination agreement to achieve its financial objectives."

For more information:

www.pg.com

INDUSTRY

Hostile bid shakes S&N Centerpulse plans

US orthopaedics company Zimmer has outbid Smith & Nephew with a £2.04 billion approach for Swiss firm Centerpulse.

The conditional offer is being considered by Centerpulse which said in a statement that "on a number of occasions it had sought to include Zimmer in the process to sell the company initiated by the board at the end of last year" but Zimmer had declined.

Smith & Nephew's £1.4bn bid has been on the table since March.

Centerpulse said it was evaluating Zimmer's proposal.

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ference: 1. IMS June 2002. 2. IMS March 2003.

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esentations: Eye Drops containing Sodium Cromoglycate 2% w/v **Indications**: Relief and treatment of seasonal and perennial allergic conjunctivitis. **Dosage & Administration (including the derly)**: One or two drops in each eye up to four times a day or as indicated by a doctor. **Contraindications**: Hypersensitivity to ingredients. **Precautions and Warnings**: Product is unsuitable use with soft contact lenses. **Pregnancy**: Caution should be advised during 1st trimester of pregnancy. Although experience with sodium cromoglycate suggests that it has no effect on foetal velopment, it should be used only when there is a clear need **Adverse Effects**: Transient stinging and burning may occur after instillation. Other symptoms of local irritation have been ported rarely. **Legal Category**: P **Pharmaceutical Precautions**: Store below 30°C and protect from direct sunlight. Discard any remaining contents 4 weeks after opening. **Retail Price**: Eye ops 5ml – £4.09. PL No 04425/0323 Eye Drops 10ml – £5.09 PL No 04425/0323 **Date of Preparation**: April 2003.

rther information is available from Aventis Pharma Ltd. 50 Kings Hill Avenue, Kings Hill, West Malling, Kent ME19 4AH, United Kingdom.

POLITICS

Hewitt probes 'rewards for failure' contracts

Hot on the heels of the much-publicised shareholder revolt at GSK's AGM last month, trade & industry secretary Patricia Hewitt has launched a new consultation exercise looking at the issue of directors' contracts and so-called 'rewards for failure' payments.

The document asks whether further measures are needed to ensure that compensation reflects performance when directors' contracts are terminated. Both best practice and legislative options are explored.

The premise of the document is that individual directors' pay is a matter for companies and their shareholders. The Government's role is to create a framework to allow shareholders to play their part in this process effectively and responsibly.

Patricia Hewitt said: "Britain has some of the best and most successful businesses in the world but the good reputation of the majority is being tarnished by the bad practice of the minority. We believe the combination of improved transparency and increased activism will mean directors' pay is better linked to company performance."

However, Digby Jones, director-general of the CBI, said: "Transparency and shareholder activism are the ways to police directors' pay, not legislation. Investors are the most credible judges of performance, not the Government or the law courts."

For more information:

www.gnn.gov.uk

www.cbi.org.uk

Patricia Hewitt intends that the consultation exercise looks at linking directors' payments to performance, but sees individual salaries as a matter for companies and shareholders rather than government

Avicenna advice

Avicenna is running a series of seminars on *Investing for the Future* starting on June 11 at the HSBC Canary Wharf building at 6 Canada Square, London.

The evening will include three presentations on equity investment, fixed interest investments and venture capital.

Independent pharmacists who are not members of Avicenna will be welcome. For further details contact Avicenna on 01883 373637.

Logistics convention

The Institute of Logistics and Transport's ILT 2003 logistics event takes place at the International Convention Centre in Birmingham from June 17-18. CBI director-general Digby Jones will give the [illegible] address. For more [illegible]

[illegible]uiries unravelled

[illegible] new directory enquiries [illegible] giving you [illegible]aiche, [illegible]newdirectoryenquiries.com where some service providers have combined to give further information. This list is not exhaustive however, as providers offer differing services

INDUSTRY

Pharmacos set up as insurers

Seven US and European pharmaceutical companies, including AstraZeneca and GlaxoSmithKline, have set up their own mutual insurance company in a move designed to cut insurance costs.

The new Bermuda-based Pharmaceutical Insurance Ltd (PHIL) will provide cover for property damage, and loss of sales due to manufacturing interruptions. According to AstraZeneca, the new company will also allow international pharma companies to overcome problems of achieving adequate cover. A spokesman said: "International pharmaceutical companies often have big sales lines, which could give rise to a huge claim."

Although each of the seven companies signed up to PHIL has made a capital contribution and has a legal commitment to membership for a number of years, each can decide individually whether to purchase cover.

AstraZeneca has also opened a tuberculosis research facility in Bangalore, India. The company will be investing around US$30 million over the next five years in laboratory and operations costs. TB affects two million people in India each year, and around eight million worldwide.

INDUSTRY

Boost for small businesses

Government plans to make the UK a small businessperson's dream get a boost with the Annual Business Plan for the Small Business Service (SBS).

The document positions the agency as "an influencer and centre of expertise on small business issues" as it sets out how the SBS plans to lead in delivering the Government's seven strategies for small business.

Coming Events

JUNE 10
RPSGB
West Surrey, Crawley, Horsham & Reigate and Epsom branches joint meeting: *Discussion on the proposed changes to the RPSGB Charter,* with Christine Gray, RPSGB modernisation programme project manager. Burchatts Farm, London Road, Guildford, 7.30-9.30pm.

NICPPET
Specialist medicines: the red/amber list, at the School of Pharmacy, Belfast, 10am-5pm.

June 11
NICPPET
Respiratory disease, at the School of Pharmacy, Belfast, 10am-5pm.

June 12
NICPPET
Return to Practice 111: Changing Practice, at the School of Pharmacy, Belfast, 10am-5pm.

June 13
ACP
Endocrine Disorders, Antrim.

June 17
RPSGB
East Metropolitan Branch meeting at the Churchill Room, Wanstead Library, Spratt Hall Road, Wanstead, E11 2RQ, 7.30 for 8pm on *A Charter fit for the future*, a presentation by Christine Gray. Buffet provided.

June 18
Infection and reducing antibiotic resistance workshop at The Fitzwilliam Hotel, Antrim 10am-5pm.

NOVARTIS

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Report RPSGB Special General Meeting

Another way forward for the Society

Upwards of 330 pharmacists attended the Special General Meeting at the Queen Elizabeth II Conference Centre in London last Sunday and approved four motions challenging the way the RPSGB has been proceeding with its modernisation agenda.

After an unseemly start, during which the authority of the president Marshall Davies was challenged with regard to who would be able to speak at the meeting, a succession of pharmacists set out reasons why they felt the Society was wrong to pursue the policy it has been doing.

This led up to newly-elected Council member Nicholas Wood introducing the first motion. This called on the Society's Council "to abandon its current preferred proposals on reform of the Society in favour of a model that would allow the Society to be operated by two separate boards; one to deal with professional representation and one to deal with regulatory matters".

Mr Wood argued: "We need a reformed Council. The reason Council has decided that it should have over 41 per cent of non-pharmacists is because the Government says so." However, he added: "We have already been told there's no alternative, to which I say, codswallop."

He announced that the Save Our Society campaign has taken leading legal advice and believes there are alternatives, although the two-board structure he was proposing, (a development of the Young Pharmacists' Group model put forward last year), would need more work on the detail.

The Queen Elizabeth II Conference Centre

Seconding the motion, another new Council member, Noel Wicks, said that a structure which incorporates a two-board model would enable the Society to fulfil both roles. "The leading legal advice taken by SOS confirms there are a number of workable models in use and this one would probably be acceptable to the Government."

Newly-elected Council member Doug Simpson said that he believed a federal structure was needed, along the lines of bodies such as the BMA. "We need a change in direction in the powers that be at Lambeth," he said. "They need to abandon their current mode of operation which is to try and find out what the Government wants and then sell it to the members."

Gordon Applebe, who retired from Council at the recent election, said that all that had been agreed by Council was that there should be a new Charter and that the members be consulted. Council had not seen or approved the version of the draft Charter that had been circulated among the members.

David Sharpe, one of the 11 past presidents who had asked the Council to consider the YPG model, said: "We have been told the regulatory role is important. But the representational role is vital.

"It appears to me that through a combination of legal advice and possible pressure, the Council is prepared to abolish our Society. We must not be bullied into this. If the Government wants to destroy us, the professional body must fight, not roll over."

Another new Council member, Martin Astbury, said that at an induction day at Lambeth the previous Friday, he had been looked after, "but the one thing that horrified me is that senior members of the Society believe [it is] already a regulator only, and that we are just registrants. I believe we are members. I have one great worry that once again we are going to be railroaded. Even if we carry this motion through, there is the potential for the 'big boys' to push through what they are already doing."

At the outset, voices from the floor had been critical. John Gentle (Shropshire) said that for the past 499 days the Society's modernisation steering group had been telling the profession what to do. However, "we are here to tell them what we want. We will not be bullied into accepting a new Charter we do not like. We will not accept the process that has been imposed on us without our consent.

"All along we were told there were no options. This Council's mantra is 'consultation, consultation, consultation' but to what end? ... if we are being implored to take this because of the Government, why bother with a consultation?"

Graham Phillips (Herts) accused the Society of "eleventh hour moving of the goal posts". "I have real concern about the direction the way some senior managers at Lambeth are leading the profession," he said. He warned of concerns that the Society could become the "Government's regulatory poodle", adding: "If the Society betrays its representative role it leaves the employees un-represented and disenfranchised".

Hassan Arghomandkhah, who lost his seat on the Council in the recent elections, used his freedom to speak outside Council corporate responsibility, to say the SGM was being held "because the Council has failed to engage effectively with the membership and called any opposition a vociferous minority".

He accused the Society of having established so many ad hoc groups with a core of Council members, it had left the other members of Council feeling isolated, meaning that Council members were finding out what was going on too late to make any difference.

Anthony Cox (Birmingham) said that he was all in favour of lay representation "but I do not want an increase in the number of lay

Nicholas Wood

Christine Glover

Sue Carter

people on our professional representational body."

Mike Williams (Solihull) was critical of how the membership had been consulted. "I want to be asked 'do we want a new Charter or should we amend the existing one?' Instead, we are being asked 'this is the new draft, does it prevent us doing anything we do not already do?' That's the wrong question."

Sue Carter (Sussex) said: "I feel angry, bewildered and astounded by Council. Unelected staff need to listen to the members. I have a sense of breach of trust. My trust in the powers that be to ensure my future has been breached. The silent majority are deeply unhappy."

Maurice Hickey accused the modernisation process of having been "consultation through not listening". The modernisation plan "has been rejected at vote after vote".

Defending the Society's action to date was Council member Nicola Gray, who said: "It's wrong to say that Council did not talk about a two-board structure or any other way. There was a proposal to look at a separation of tasks, but where does a regulatory issue stop being a professional issue and where does a professional issue stop becoming a regulatory one?" she asked.

She also questioned why lay members should be kept off a professional board. "What is more powerful in a government or in influencing paymasters? Is it the pharmacists' voice or someone outside the profession?"

Fellow Council member Andrew Burr said that although he was a former chairman of the YPG he could not support the motion. He asked the meeting to recognise the strength lay members would bring.

However, Graham Phillips replied that no-one at the SGM was voting against lay representation. "What is proposed is a regulatory board with a high level of lay representation and a professional representation board with an adequate level of lay representation. There's nothing to stop us working with patients, for example with patient groups."

Council member Sultan Dajani pointedly told other Council members that they should have read their paperwork more carefully, as recommendation 39 of the Kennedy Report says it would be possible to have two overarching boards. Answering Dr Gray's point, he said the report says issues of overlap must be resolved.

Christine Glover said that Council had considered the YPG two-board model "but we have had extremely strong indications that this is not acceptable because the Government wants Council to be accountable, not just a distant committee.

"We are already behind the other regulators and we are last on the list. If that's what you want, fine. But it has to be a model that more or less conforms.

"Regulation now, more or less, covers all those things you think are professional. All those things will be taken away .We will be left with some branch stuff and PR. We will become a trade union. But that's not what you want."

The first motion was carried two hours after the debate began.

The second motion, relating to the inclusion of an object supporting the promotion of the profession was moved by Mark Koziol, who said that the objects that appear in the Society's Charter are the very essence of what the Society is all about. However, the new draft Charter proposed that the promotion of the profession would only become a power. "The change would be catastrophic," he said.

Attacking the way the draft Charter had been put out to the membership, Dr Applebe said that the Council had not discussed the draft. "I believe we should have a new Charter. We needed one 15 years ago, not today. But it has to be properly done; not only in the public interest but also in the interests of the profession.

Former Council member and member of the Scottish Executive Claire Mackie said that she was incensed by Nicola Gray's comments earlier. "Pharmacist prescribing maintains much strength and support from lay members, not because of the RPS which impeded pharmacist prescribing.

"The reason I stood for Council membership was to support this. I resigned 30 months in because I was disappointed."

Clarifying matters, secretary and registrar Ann Lewis said that Council did approve that a draft Charter should be issued but it did not approve the draft version that was issued. However, answering the question from Michael McDonald as to why the object which promotes the interests of members had been deleted from the draft Charter, she said: "I do not know the answer to your question."

Mr Koziol summed up by saying he was alarmed about what kind of message the omission of the object from the draft Charter was giving to the outside world and the Government. "This object is not negotiable now, not negotiable in the future and it's not negotiable ever," he said.

The final motion to be debated, that of holding a referendum of the members before any new Charter is adopted, prompted Dr Applebe to comment that it caused him concern as that should be the last step in the process. "I believe that when the Society drafts for the first time the new Charter it should go to the membership for consultation. It may be that there are changes that the membership would wish. Not all the expertise sits round Council; not all legal opinion is right, it's merely opinion."

Will it make a difference?

The president, Marshall Davies, had started the day by saying: "The Council understands your strong feelings and your concerns. We will take back the detail and ensure the Council is fully informed of your views. The meeting has been called because of your high regard for the Society.

"The SGM is one opportunity for you to convey your views on the issues set out. The Council will then give due weight to them and to the debate itself but it will not be possible for me to give any indication of how Council will respond to the motions, but it will consider the motions in due course."

The *Council Governance Handbook*, setting out details of how the Society operates as well as the code of conduct for Council members, says that the Society's byelaws do not make provision for a resolution or a motion carried at a general meeting to have any particular status. "As a result, they do not derogate from the powers of the Council set out in Article 12 of the Charter. Their status, therefore, is that of an influential expression of opinion, and no more."

Comment from the Editor

Sunday's special general meeting of pharmacists to discuss the RPSGB modernisation process left a sour taste in many mouths. It prompted a long list of questions about how so many pharmacists could feel so disenfranchised by activities at Lambeth.

Despite being called by the membership, the meeting was not a case of all members together, but more a case of 'them and us'. It was an ill-conceived idea for the chair to try and impose a set of double standards as to which non-pharmacist experts could speak. This simply engendered more distrust.

For many it is worrying that Lambeth (with its unelected team of administrators) is not prepared to fight the Government for what the members apparently want. But more sinister is the fact that some Council members (both serving and former) are apparently so bound and gagged by their code of conduct and collective responsibility that it takes an SGM for them to express their true feelings. One former member accused the Society of delaying the introduction of pharmacist prescribing. Another suggested that Lambeth has one clique too many.

So much anti-Lambeth feeling at grass roots level should set alarm bells ringing: the Society's communication policy – which has never been its forte – has really failed this time. The membership has exploded because not enough was done by Lambeth to dissipate strong sentiments through better communication. Pharmacists may have been told but have they been informed?

Council has discussed many scenarios for the modernised Society and many have had to be rejected because they do not fit in with this Government's idea of what a 'modern regulator' should be. Fine. But why not explain this more fully?

The Banks Report a few years ago brought in new ways of working at Lambeth. But have they been audited, as clearly something is wrong? Might it be that the directorates have too much power, leaving the Council the task of rubber stamping?

Pharmacists may have been told but have they been informed?

Yourviews

Ple@se e-mail your views to chemdrug@cmpinformation.com

A Scottish angle on the draft RPSGB Charter

It is an indication of the robustness of the 1953 Charter that it is only now, 50 years later, that we are examining whether it continues to meet the needs of the profession.

Much has changed in the intervening years. It is therefore right that Council now addresses this issue. Clearly, any new Charter should aspire to achieve a level of robustness similar to that of its predecessor, and reflect the changes required in relation to the Society's dual professional and [illegible]

The establishment of the Scottish Council on July 1, 1999, fundamentally changed the political and administrative face of Scotland. The NHS across the United Kingdom is currently undergoing rapid change. It is likely that each of the four health administrations will develop in different ways. In particular, through the Scottish Parliament, there is a clear desire to adopt Scottish solutions to Scottish problems.

The Scottish Department of the RPSGB is currently established by way of Article 16 of the 1953 Charter, and the Scottish Executive, its democratically elected body, by existing Byelaw.

Article 6(4) of the proposed Charter falls short of that required to meet the needs of the profession in Scotland, where responsibilities for health, community care and social justice are all devolved to the Scottish Parliament. It is essential that the RPSGB continues to recognise a separate need for a suitable Scottish structure within any new Charter.

Though similarities exist across the various UK pharmacy plans, there are significant differences in both emphasis and priority. In meeting the healthcare needs of the Scottish population, it will be essential that Parliament and the Scottish Executive Health Department are able to draw on local expertise and benefit from pro-active advice.

We believe that effective responsibility must be delegated to the Scottish Department's governing body, the Scottish Executive. Failure to do so will not serve the needs of the Society's members in Scotland and will result in missed opportunities for pharmacy.

Article 3 of the draft Charter allows Council to dispose of property whatsoever or wheresoever situated, with Article 6(2) permitting that any such actions which require a special general meeting are set out in regulation.

We consider that any sales or purchases in Scotland as proposed by Council should only be made with the approval of the Scottish Executive of the Scottish Department.

We believe the current draft Charter fails to recognise fully the needs of the profession in Scotland. It will be important that Scottish concerns are aeknowledged in any revisions, and that we be provided further opportunity to comment on those revisions as and when they are made.

Frank Owens, Falkirk
Ron Shiels, Culloden.

Northern Ireland NOTEBOOK

Council wants more

So PSNI is looking for more money. Last year our professional body consulted on a hefty 15 per cent rise in the retention fee. This year again another consultation on another rise – this time 13 per cent (*C&D May 17, p5*).

I agree £170 a year is a modest membership fee. I make a good living from pharmacy and this rise will not inflict much pecuniary hardship. But on the other hand what do I get for my fee?

Colleagues across the water get a weekly journal, information, policy, a Code of Ethics. They get effective representation on key bodies and they talk to and affect government thinking.

We were promised change in recent years but where's the difference? In the last consultation the fee rise was needed to employ a training person. Has anyone been appointed to this post yet? That was 12 months ago and I have heard nothing. I read *C&D* weekly in a vain hope of insight. And now I hear of an impressive business plan purporting to justify additional funding.

We were promised change in recent years but where's the difference?

Details are sketchy but PSNI anticipates two Statutory Committee meetings per year. It might be news to Council but we've been paying for the Stat Comm for over 75 years! And why this mad rush to modernise? The RPSGB did not need the painful root and branch modernisation programme it's recklessly pursuing. It's merely sucking up to government and would do better to look after those it represents.

We would be much better served if PSNI were a branch of the RPSGB like Scotland and Wales. I might not be any happier with my professional body but they would communicate and I would know why I was unhappy with them.

Written by a practising community pharmacist in Northern Ireland

TOPICAL REFLECTIONS

Educate PCTs on what the contract can do for them

The pressure on the Government to view constructively its promised proposals for changes to the limitation of contract regulations continues intensely. Most of this activity emphasises the damage too much change could do to the provision of community pharmaceutical services but the Pharmaceutical Services Negotiating Committee has now gone one stage further and published its proposals to revise the present regulations (*C&D May 31, p4*).

But I am concerned. PSNC suggest a further move towards local determination but even with national guidelines I do not believe my local primary care trust will ever fully understand community pharmacy. They do not understand the way the present remuneration contract works and I cannot believe they will be any better at understanding its proposed service-based successor because the motivation is absent. Primary care starts with the GP, rotates through the nurses and ends with the GP.

I am also concerned about reducing the role of the Special Health Authority in Harrogate. I can foresee a situation where I might consider a decision by the PCT to be perverse but which, within the regulations, could be argued as being fair and superficially reasonable. It would require a fresh hearing by a disinterested authority to expose the perversity. In other words, the situation that presently exists. It may be expensive but it is effective and does protect me from the inconsistencies of local decision making.

I have always supported a fee being charged for all applications but a cooling off period is a prescription for disaster. If the case is bad the administrative fee will be lost and if local circumstances do not change then any future applications will also be lost. A fee sufficiently high to deter spoiling applications should be enough, whereas a cooling off period could stifle genuine competition.

As for tinkering with words like choice, access and convenience, these have different meanings depending on interpretation. It is not the eventual words that are so important as the acceptance by government that these words should even exist.

Big brother or pharmacist accountability?

Record keeping is one of those activities that I have never fully implemented and I am not alone. Last week a coroner, Dr Nigel Chapman, urged all community pharmacists to maintain full patient notes including advice given on prescribed medicines, over the counter and even over the telephone (*C&D, May 31, p25*).

Now I understand why Dr Chapman is so concerned about records. After all, he is a coroner, but he does raise an important consideration that is, unfortunately, easier to propose than to implement.

For all advice and interventions to be recorded I need time and the co-operation of my customers. Now some may be prepared to accept the restrictions required for recording all activities but others may resent this intrusion.

One of the areas that differentiate pharmacy from other healthcare services is the informality associated with the relationship. The patient is not only able to access easily the pharmacy of their choice but they are under no compulsion to provide information. This has resulted in an environment of trust that enables pharmacists to work effectively in the community. The implementation of strict record keeping could undermine that trust and irrevocably destroy the relationship between patient and practitioner that is community pharmacy.

A powerful claim

Inexorably, herbal remedies are moving towards a licensing system that should bring order out of chaos. There is resistance to these changes, particularly from manufacturers who would prefer not to expose their products to the scrutiny of the licensing authorities but as a responsible professional I fully support the moves.

Meanwhile brave claims are still made in the battle for market share. Only last week an advertisement appeared in *C&D* suggesting I purchase *The Scandinavian Detox Plan* for sale to my customers. And the claim? "Proven formulation using 10 herbs to cleanse the body of toxins."

A strong claim but in the absence of a licence where is the evidence? Am I expected to take the word of the manufacturer and then provide my professional endorsement?

Tutorial No26

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THE COLLEGE OF PHARMACY PRACTICE

This tutorial has been designed to meet the requirements of the College of Pharmacy Practice in providing one hour of postgraduate education towards the College's continuing education requirement

The protocols for treating acute diarrhoea have recently been updated. With the summer holidays approaching, pharmacists need to make sure the advice they are providing is current

Objectives

- To be aware of the incidence of traveller's diarrhoea
- To understand the underlying causes of the condition
- To know what the new treatment protocols for acute diarrhoea are
- To be able to advise customers on appropriate self-treatment
- To be able to advise on preventative measures

Traveller's diarrhoea

With more people journeying overseas, traveller's diarrhoea is now the most common health condition facing travellers. Some 80 per cent of all sickness suffered abroad is gut-related, and it can spoil a holiday unnecessarily if it is not managed properly.

Pharmacies are an important source of information and advice on the best ways of treating the condition, and how to avoid suffering from it in the first place. Recent guidelines on the management of acute uncomplicated diarrhoea, and changes in the *BNF*, have led to a new approach to treating traveller's diarrhoea.

Traveller's diarrhoea refers to acute diarrhoea acquired when a person travels abroad, whether on business or for pleasure. It can range in severity from mild symptoms that last from two to four days to a severe condition that is more debilitating, lasts longer and is accompanied by pain and fever.

Diarrhoea is characterised by an unusually urgent or frequent need to go to the toilet and the passing of loose, unformed or watery stools. Travellers who fall ill with stomach-related illnesses spend up to 15 per cent of their holiday confined to their hotel room unnecessarily.

Between 20–40 per cent of travellers suffer diarrhoea to some degree, but that figure rises to 50 per cent when people are travelling to developing countries. It is estimated that over 20 million people travel from developed to developing countries each year, where the risk of suffering traveller's diarrhoea is greatest. Such areas include Turkey, South America, South-East Asia, Africa, China and India.

Causes

Traveller's diarrhoea is a bacterial-derived diarrhoea and the most likely cause is consumption of contaminated food or water, or exposure to new varieties of bacteria that normally live in the gut. The risk of diarrhoea can also depend on the public health system of the country being visited and local standards of hygiene.

Untreated tap water is the main source of infective bacteria. Even in popular holiday destinations such as Greece and Spain, the local water is not treated and should therefore be avoided as it can harbour diarrhoea-causing bacteria. Bottled or cooled boiled water is always recommended for drinking and, in more exotic locations, for brushing teeth and washing salads and vegetables. Customers should be reminded of the adage 'boil it, cook it, peel it or forget it'.

The bacterial gut flora in people varies from country to country. These bacteria live harmlessly in the local population, but travellers whose immune systems have not been exposed to the new bacteria will succumb to diarrhoea. People can become contaminated when anything comes close to the mouth. It is therefore important that people wash their hands regularly to avoid picking up bacteria and transferring to the mouth.

Non-bacterial diarrhoea is also common whilst abroad and can be triggered by over-indulgence in rich/spicy food or alcohol. Even a change in climate or routine can affect speed of digestion and it only takes a 2 per cent change in this to bring on a bout of diarrhoea.

New thinking on diarrhoea

The treatment protocols of acute diarrhoea have been updated since the publication of new guidelines by an international panel of leading gastroenterologists, led by Professor D Wingate at St Bartholomew's and the Royal London School of Medicine and Dentistry (*Aliment Pharmacol Ther 2001; 15: 773-782*).

These guidelines dispel the confusion among health professionals that currently surrounds the treatment of acute diarrhoea. Many think that acute diarrhoea is a natural defence mechanism used to excrete toxins and pathogens from the body. In fact, diarrhoea occurs when something irritates the lining of the gut, speeding up peristalsis and causing waste to be pushed out of the body at a faster rate. This increased rate of peristalsis leads to less water and nutrients being absorbed into the body and more frequent, loose and unformed stools.

Another commonly held belief is that antimotility drugs 'bung up' the digestive tract and lock in pathogens, causing further harm and deterioration of the individual's condition. These drugs simply slow the digestive system

back to normal speed and help restore its natural balance.

The new guidelines state that self-medication of acute diarrhoea relieves discomfort and social disruption, and is safe and effective for otherwise healthy adults and there is no reason to withhold treatment. The panel concludes that the balance of evidence suggests that antimotility medication such as loperamide may diminish diarrhoea and shorten its duration, also reducing fluid loss at the same time. It is therefore better to treat than not to treat. Pharmacists can obtain a copy of the latest guidelines from their J&J.MSD representative or by calling J&J.MSD on 01494 450778.

The *BNF* has also revised its section on acute diarrhoea to recognise the role of antimotility drugs in the management of uncomplicated acute diarrhoea in adults, such as traveller's diarrhoea.

Management of diarrhoea

Self-medication is appropriate:

- following sudden onset of increased bowel action with loose watery stools
- in persons over 12 and under 75 years of age
- in people previously in good health
- provided the individual is not suffering from any other serious illness
- in the absence of warning signs, eg high fever, blood in stools, vomiting, dehydration.

Treatment options for traveller's diarrhoea are:

Antimotility agents – these include loperamide, codeine phosphate and co-phenotrope. Only loperamide is available OTC, while the other two are POM as there is a risk of dependence with long-term use and of effects on the central nervous system.

Antimotility drugs containing loperamide, such as Imodium, promote fluid absorption in the gut by normalising transit through the gut and restoring normal stools. Constipation is reported in less than 1 per cent of patients and in the first 24–36 hours after taking medication, the perception of being 'bunged up' is simply a reflection of the gut returning to its normal transit time.

Loperamide is also combined with the anti-flatulent simethicone in Imodium Plus to provide faster relief of diarrhoea and relieve the cramping pain of trapped wind and bloating associated with diarrhoea and experienced by over 70 per cent of sufferers.

ESSENTIAL INFORMATION. IMODIUM PLUS
For further information contact the PL holder (see below) Presentation: Chewable tablet containing Loperamide Hydrochloride 2 mg and Simethicone equivalent to 125 mg polydimethylsiloxane. Indications: Symptomatic treatment of acute diarrhoea associated with gas related abdominal discomfort. Dosage: Adults and children over 12 years: two tablets initially followed, if necessary, by one tablet after each loose bowel movement. Maximum of four tablets in 24 hours. Course to continue for a maximum of two days. Contraindications: Hypersensitivity to any component of the product. Price: 6 tablets £3.45, 12 tablets £5.75 and 18 tablets £7.95. Legal category: P. PL no: 13249/0020. PL Holder: Johnson & Johnson MSD Consumer Pharmaceuticals, Enterprise House, Station Road, Loudwater, High Wycombe, Bucks HP10 9UF.

Oral rehydration therapy (ORT) is necessary when diarrhoea is accompanied by vomiting or for babies, children, the frail and those over 75 who are more prone to dehydration and its complications. In normal healthy adults with uncomplicated diarrhoea, fluid loss can be stemmed by taking an antimotility drug and maintaining fluid intake as dictated by thirst.

Adsorbents and bulk-forming drugs – these are not recommended for acute diarrhoea because of uncertain efficacy, delay in onset of action or potential adverse effects. Kaolin absorbs excess fluid in the bowel but does not help with rehydration or settling of the bowel.

Probiotics – probiotics such as *Lactobacillus*, *Bifidobacterium*, *Streptococcus* and yeast *Saccharomyces* may influence the composition of gut flora but there is no evidence that they prevent or treat acute diarrhoea in adults.

Advice for travellers

Pharmacists should also inform customers of destinations where traveller's diarrhoea is common and recommend that they take antimotility drugs with them as a precaution, and oral rehydration therapy for children and the elderly.

They can also direct consumers to the Imodium website for further information (*www.imodium.co.uk*) and to order the free *Passport to Healthy Travel* booklet.

In addition, customers should also be given the following advice:

- only drink sealed bottled water or water that has been boiled. Use purifying tablets as a precautionary measure
- avoid ice cubes in drinks
- check that all dairy produce has been pasteurised
- don't brush teeth with tap water
- drink bottled beverages
- avoid salad, raw vegetables and unpeeled fruit
- avoid snacks from roadside vendors unless it is freshly cooked and piping hot
- avoid food which has been exposed to flies or the sun
- make sure food is served piping hot
- avoid buffets where food has been standing around at room temperature
- eating the local yoghurt may help as it will contain gut-friendly bacteria
- if you get diarrhoea, drink plenty of fluids
- seek medical attention if there is fever, blood in stools or if diarrhoea is prolonged (more than a week) and severe, or is affecting children and the elderly.

Always read the label

Test your understanding

Test your understanding by answering the following questions, then check your answers by phoning our Telephone Marking Service on **08705 800 287** for an immediate result. You will be asked for the Tutorial Number. This tutorial is No26. Just listen to the instructions and press buttons 1 or 0 to indicate your answers. "1" indicates true; "0" indicates false. The telephone line will close on July 7, 2003. Please note that calls are charged only at standard national rates.

This module also appears on the *C&D* website, *www.dotpharmacy.com* under 'Education'.

If you want a certificate to confirm you have completed this College of Pharmacy Practice accredited course, complete the form below and send the original (or a photocopy) to: Mary Prebble, Pharmacy Editorial Projects, CMP Information Ltd, Sovereign Way, Tonbridge, Kent TN9 1RW. Please enter your name and status (please tick), pharmacy, address, phone and RPSGB/PSNI number below:

Name

Address

Pharmacist ❑ Registration No

Technician ❑ Counter assistant ❑

Signature

1 Over 80 per cent of all travellers suffer from diarrhoea to some degree
❑ True ❑ False

2 Turkey is a high-risk area for traveller's diarrhoea
❑ True ❑ False

3 Traveller's diarrhoea can be caused by drinking untreated tap water
❑ True ❑ False

4 Acute diarrhoea is the body's natural defence mechanism to excrete toxins and pathogens
❑ True ❑ False

5 Antimotility drugs such as loperamide are contraindicated for the treatment of traveller's diarrhoea
❑ True ❑ False

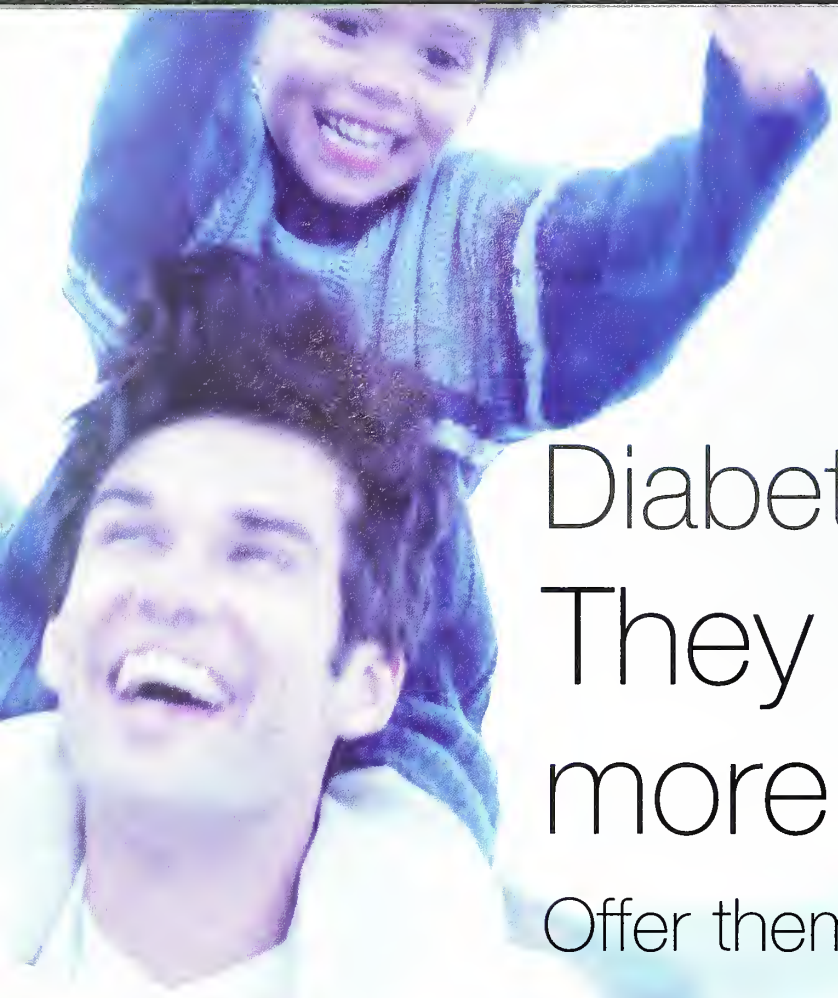
6 Loperamide may be taken by adults and children aged over 6
❑ True ❑ False

7 Antimotility drugs promote fluid absorption in the gut
❑ True ❑ False

8 Oral rehydration therapy should be used as an adjunct to loperamide in healthy adults with uncomplicated diarrhoea
❑ True ❑ False

9 Oral rehydration therapy should be considered if diarrhoea is accompanied by vomiting
❑ True ❑ False

10 Probiotics may influence the composition of the gut flora and help treat acute diarrhoea in adults
❑ True ❑ False



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Women who complain of being spotty, overweight and hairy may be suffering from a common metabolic disorder that could affect fertility and have long-term health consequences, not just vanity. *Vanessa Sherwood* looks at polycystic ovarian syndrome

Bad hair day?

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This course (module 1272), in association with multiple choice questions being published in C&D July 5, provides one hour's continuing education

Objectives

- To be aware of the symptoms of PCOS
- To understand the possible causes of the syndrome
- To understand how PCOS is diagnosed
- To appreciate the importance of lifestyle advice
- To be aware of drug treatments for PCOS

Polycystic ovarian syndrome is a multi-factorial condition, affecting women of reproductive age. It is the most common cause of anovulatory infertility.[1]

However, as celebrity mothers such as Victoria Beckham and Jools Oliver, both sufferers, have each had two children, the effects of PCOS on fertility are not necessarily insurmountable.

PCOS may also be known as Stein-Leventhal syndrome, sclerocystic ovaries or polycystic ovarian disease.

Egg production

Normally, an ovary consists of fibrous tissue containing immature, preformed follicles. Each follicle contains an oocyte, a precursor of an ovum, surrounded by follicular cells. About half a million follicles are formed during foetal life and approximately 500 of them mature during adult life. The remainder, usually undeveloped follicles, degenerate and all are lost at the onset of the menopause.

The growth and release of the ovum is controlled by follicle stimulating hormone (FSH) and luteinising hormone (LH) respectively.

Multiple follicles

In polycystic ovarian syndrome, some follicles develop to a mature stage but do not rupture to release the ovum and this, in turn, prevents the normal hormone cycle being initiated. These mature but unruptured follicles congregate on the outer surface of the ovaries and are described as cysts.

PCOS sufferers may have 10 or more follicle cysts in each ovary.

Ultrasound findings often include multicystic ovaries with the follicle cysts lining up on the periphery of the ovary. The ovary then secretes higher levels of testosterone and oestrogen, resulting in the most common presenting symptoms: irregular or missing periods, infertility, excess body hair growth, often obesity, insulin resistance or diabetes and hypertension, male-pattern baldness and abnormal serum lipid concentrations.

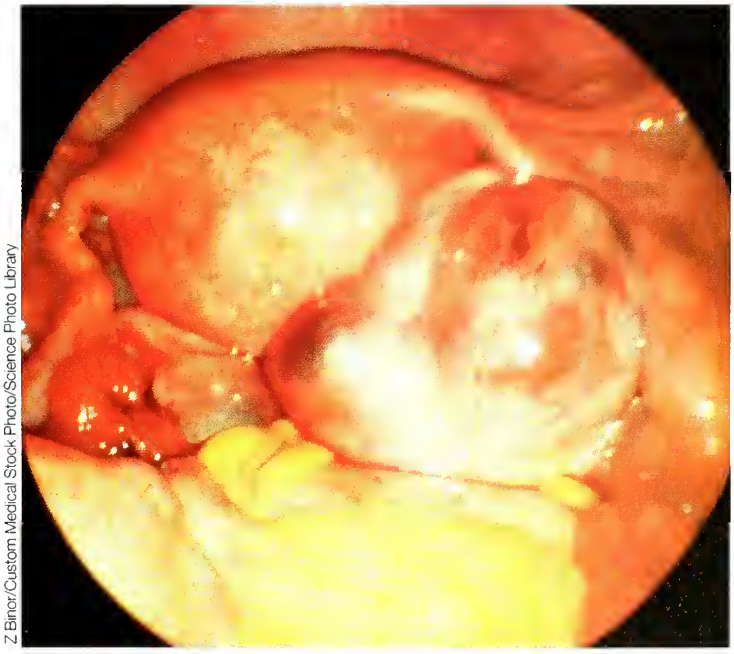
Because of the problems with insulin resistance and abnormal lipids, women with PCOS are at a higher risk of diabetes and cardiac problems than women of the same age without the syndrome.

How common is PCOS?

The estimated prevalence depends on the symptoms used to define PCOS but is in the range of 5-10 per cent of pre-menopausal women. Definition and diagnosis of PCOS varies between countries. In the USA ultrasound of the ovaries is not required to make the diagnosis – clinical features such as hirsutism, male-pattern baldness and acne along with ovulatory dysfunction are all that is required.[2] In the UK ultrasound examination of the ovaries is used to confirm a diagnosis.

What causes PCOS?

As it is such a complex disorder with many hormonal factors playing a part there have been many theories about the cause of PCOS.



Z Binor/Custom Medical Stock Photo/Science Photo Library

A view inside a woman's abdomen showing a polycystic ovary. At the centre right is the ovary (white), grossly enlarged and deformed in shape with grey cystic follicles bulging on its surface. The uterus is seen at the upper left (pink) with its two fallopian tubes, one leading to the affected ovary. The ovarian follicles enlarge, fill with fluid, and become sterile

Around 40 per cent of sufferers have raised levels of LH and 30 per cent have raised levels of testosterone.

LH stimulates the ovary to produce testosterone and consistently raised levels of LH can prevent ovulation.

There is some debate as to whether the insulin resistance associated with PCOS is a cause or effect of the syndrome. Recent evidence has suggested that the principal underlying disorder may be insulin resistance with the resultant raised serum insulin concentrations stimulating excess ovarian androgen production.[3]

Excess circulating insulin also reduces the production of proteins that bind sex hormones, increasing the free testosterone levels.

A high body mass index could also be a cause or effect. Increased weight can lead to increased serum insulin concentrations and, as described above, increased free testosterone levels.

There may be a genetic factor but this remains controversial. PCOS is a complex, 'chicken and egg' hormonal syndrome. As such, there is no cure but the

Continued on page 22

emphasis lies in treating the symptoms.

Diagnosis

Women present with the classic symptoms of PCOS as described previously rather than with the syndrome. Diagnosis can be difficult because of the varying definitions of "normal". Excess body hair for one woman may be normal for another.

Typical investigations include an ultrasound of the ovaries and blood tests to measure hormone levels. Further examinations with CAT scan, MRI, biopsy or laparoscopy for diagnosis are usually unnecessary.

Only 50 per cent of women with classic polycystic ovaries on examination also have hirsutism and anovulation. Characteristic hormone levels for PCOS would be testosterone between 2.6–4.8nmol/l (normal 0.7–2.8nmol/l) and LH above 10IU/l.

Women who present only with hirsutism should just have testosterone levels measured. Hair growth in PCOS is usually gradual but women who present with sudden hair growth and serum testosterone above 4.8nmol/l should be investigated as this could indicate adrenal hyperplasia and/or an androgen-secreting tumour.

In women with menstrual disturbances measurement of FSH, prolactin and thyroid hormones in addition to LH are useful to rule out any other reasons for menstrual disturbance.

Concentrations of FSH, TSH and prolactin are normal in women with PCOS but the increased level of LH alters the LH to FSH ratio.

Fasting serum glucose should be measured in women with a body mass index above 27. Lean and obese women with PCOS can show decreased insulin sensitivity but insulin resistance is most marked in those with a BMI greater than 27.

There is decreased sensitivity to insulin in peripheral tissues (muscle and adipose tissue) but not – unlike type 2 diabetes – hepatic resistance.

Insulin resistance is uncommon in women with hirsutism, hyperandrogenaemia and polycystic ovaries who have regular menstrual cycles; they have insulin sensitivity similar to those in weight matched normal subjects.

It is unlikely that anovulation is the cause of insulin resistance – it is most likely that increased serum insulin concentration and insulin resistance contribute to anovulation.

GPs should refer patients to specialists when infertility is the presenting problem or when the diagnosis is in doubt.

PCOS may be used to cover the following conditions:

- traditional PCOS – ... increased androgens, ... resistance
- ... syndrome X – ... increased androgens, ... resistance or type 2
- ... PCOS – ... normal androgens, ... resistance or type 2
- ... increased androgens, ... resistance
- ... ism – ... increased androgens, ... resistance.

PicSelect

Victoria Beckham: she suffers from PCOS

Treatment

Drug, non-drug and complementary: restoring ovulation and decreasing the testosterone levels are usually the main goals of therapy but weight loss and the prevention of endometrial cancer are also important considerations.

However, the symptoms the woman finds most distressing or upsetting are likely to be treated first, and this will probably depend on her age. A young woman in her late teens or early 20s may be more concerned with acne and hirsutism, whereas an older woman in her 30s wishing to start a family may be more concerned about her irregular periods and inability to conceive. The treatment of each symptom will be considered individually.

Irregular periods: the combined oral contraceptive pill can be used to regulate periods. It reduces free testosterone levels by decreasing androgen secretion and increasing levels of sex hormone-binding globulin. However, it can exacerbate insulin resistance and is unsuitable for obese patients.

By promoting regular periods combined oral contraceptives can reduce the risk of endometrial hyperplasia. The progestogen used should be one with low androgenic potency such as norgestimate (Cilest) and desogestrel (Marvelon and Mercilon). Norgestrel and levonorgestrel are not recommended.[4]

Progestogens alone are used where the woman's primary concern is restoration of regular periods, and not the treatment of infertility or hirsutism. Medroxyprogesterone acetate, 5–10mg daily for 10–12 days every month, or every other month, will prevent the development of endometrial hyperplasia and, in the long term, protect against endometrial cancer.

Hirsutism: can be reduced by the use of anti-androgens such as cyproterone acetate. In combination with ethinyloestradiol (for example, Dianette) it may regulate the menstrual cycle and provide effective contraception. In the USA spironolactone (100mg once or twice daily) is frequently used to treat hirsutism. The mode of action of both drugs is inhibiting the binding of dihydrotestosterone to its receptor at the hair follicle. Beneficial effects can be seen after three months but the hair growth will resume if treatment is stopped.

Flutamide and finasteride have also been used as anti-androgens, again mainly in the USA. Flutamide has a similar action to cyproterone and spironolactone, while finasteride inhibits the activity of the enzyme 5-alpha reductase. This converts testosterone to the more potent dihydrotestosterone.

Side effects of anti-androgens include menstrual irregularity, hyperkalaemia, dizziness and gastrointestinal effects. All are contraindicated in women trying to conceive.

While waiting for the drug treatment to become effective women can use cosmetic methods of hair removal such as waxing or electrolysis. Neither is available on the NHS and the cost of the latter may be prohibitive for some women.

Acne: can be helped by the use of anti-androgens, but may take three to six months. Dianette is licensed for the treatment of acne but in the absence of any improvement usual treatments for acne are used, such as topical or systemic antibiotics or isotretinoin.

Male-pattern baldness: this symptom may take longer to respond to anti-androgenic treatment or may not respond at all. Again, symptoms will recur when treatment is withdrawn.

Infertility: Clomifene citrate is the drug of choice in PCOS but is associated with an increased risk of multiple pregnancy. It works

Continued on page 24 ▶

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by inhibiting the oestrogen-mediated negative feedback loop at the hypothalamus, enhancing the secretion of FSH.

In the treatment of hyperandrogenic, anovulatory women clomifene has been reported to increase the frequency of ovulatory cycles by 80 per cent and the rate of pregnancy by 67 per cent. Treatment is less likely to be successful in women who are overweight. It should not be used for more than six months because of the potential increased risk of ovarian cancer.

Those women who do not respond to clomifene usually respond to exogenous gonadotrophins but this requires intensvie monitoring by a specialist to reduce the risk of multiple conceptions.

Obesity: weight loss can restore ovulation and women with PCOS should be offered lifestyle advice incorporating diet and exercise. Obesity can also aggravate insulin resistance and therefore weight loss is important in controlling two features of the syndrome. However, women with PCOS find it extremely difficult to lose weight but it is not known why.

Insulin resistanee: as recent evidence has suggested that insulin resistance may be a cause and not an effect of PCOS, then treating insulin resistance has the potential to be the most appropriate action.

Metformin has been the most commonly used drug in small trials but it is still not licensed for the treatment of PCOS. Trials have shown that metformin (1,500 -1,700mg/day):

- reduces concentration of fasting serum insulin, androgens and LH
- increases levels of sex hormone binding globulin, reducing free testosterone
- restores regular menstrual cycles and ovulation.

Some people have also lost weight despite continuing with a normal diet and lifestyle. Metformin should only be [illegible] women with normal renal and hepatic function.

The use of metformin and clomifene together may have a synergistic effect. In a small trial of 61 women, 90 per cent of those receiving both drugs ovulated compared with 8 per cent of those who just took clomifene plus placebo.

Troglitazone, a thiazolidinedione, also had a beneficial effect on insulin resistance and circulating androgen levels but it was withdrawn in 1997 because of hepatotoxicity.

The newer thiazolidinediones, such as rosiglitazone and pioglitazone have reduced hepatotoxicity but no trials have yet been carried out for PCOS. GlaxoSmithKline, manufacturer of rosiglitazone (Avandia) says that it has no plans to run any trials of its use as a treatment for PCOS. However, the company was aware of one published case where a 25 year old woman with PCOS was treated with rosiglitazone 4mg daily for five months.[5] Rosiglitazone improved insulin sensitivity and lowered serum-free testosterone and resulted in spontaneous ovulation and conception.

Complementary therapies: Saw palmetto 320mg daily may be effective in reducing the effect of androgens as it works in a similar way to finasteride – blocking the efficacy of 5-alpha reductase on receptors in benign prostatic hyperplasia. However, there is no evidence to support its use in PCOS.

Surgery

Surgery is a last resort. In women who have tried all other medications ovarian diathermy "drilling" or electrocautery by laparoscopy may induce ovulation, by reducing ovarian steroid production. Formerly ovarian wedge resection was used – a small "wedge" or section of ovary was removed under general anaesthetic. All surgical treatments can cause adhesions, which worsen infertility.

Associated risks

Endometrial cancer

Because of anovulation, and risk of irregular and heavy menstrual bleeding, women are at risk of endometrial hyperplasia and even endometrial cancer.

Cardiovascular disease

PCOS sufferers exhibit raised triglyceride and decreased high-density lipoprotein concentrations, both strongly linked with cardiovaseular disease. Discrepaneies in lipid levels between sufferers and non-sufferers matched for weight and age are evident at an early age.

Retrospective studies have also shown increased evidence of eardiac disease. In one study, women who had been treated for PCOS 20-30 years earlier were four times more likely to have hypertension and seven times more likely to have diabetes than controls.

Future developments

Authors of a study in the *BMJ* have said there is an urgent need for randomised, placebo-controlled trials to assess the potential benefits of treatments such as metformin. Dr Zoe Hopkins, a clinical research fellow at the Glasgow Royal Infirmary University NHS Trust said: "Treatments targeting the key factor in the disorder may not only resolve the gynaecological problems the syndrome presents but may also reduce the risk of vascular disease in later life."

Pharmacist's role

Women with a diagnosis of PCOS should be counselled on the importance of losing weight (if necessary) and maintaining a BMI in the normal range (20-25), by eating a healthy diet and exercising. The importance of this for their long-term health prospects, not just immediate effects, should be explained.

References:
1. Frank, S. Polycystic ovary syndrome. N Engl J Med 1995; 333: 853-861.
2. Tackling polycystic ovarian syndrome. Drug and Therapeutics Bulletin 2001; Vol 39 No 1.
3. Hopkinson, ZEC, Sattar N, Fleming, R, and Greer, I A: Polycystic ovarian syndrome: the metabolic syndrome comes to gynaecology; BMJ 1998; 317: 329-332.
4. Patel, SR and Korytkowski, M T: Treating polycystic ovarian syndrome: today's approach. Women's Health in Primary Care 2000, Vol 3, No 2.
5. Cataldo, NA et al: Fertility and Sterility 2001, 76 (5); 1057-1059.

For more information:
Patient support group:
www.verity-pcos.org.uk

Actionplan

1. Do you have any patients who have polycystic ovarian syndrome? How many? Do any have children? Did they have multiple births? Was fertility treatment required by these women? If so, do you know what was used?
2. Think about these women. What are their symptoms? Would you recognise them by their appearance? What drugs were or are being preseribed?
3. Irregular periods are not uncommon. In your practice workbook list some other likely eauses. Do you know of any of your patients who have irregular periods which are not the result of polyeystie ovarian syndrome? Are they receiving drug treatment and if so whieh drug(s)?
4. Are there other uses of saw palmetto? Try to find out if there are other alternative medicine drug therapies or complimentary medieine treatments for the symptoms of polycystic ovarian syndrome.

[illegible] learning for pharmacists

[illegible] **Pharmacy Update** for continuing education are reminded of the need to test. With the [illegible] Pharmacy [illegible]. C&D's readers can self-test their progress by using the multiple choice [illegible] paper [illegible] published in the July 5 issue, which will cover this week's CPP-accredited modules, [illegible] in the last [illegible] and 28 issues. These will cover:

- **[illegible] ovarian syndrome (1272)**
- **Foetal development part 2 (1273)**
- **[illegible] part 1 (1274).**

[illegible] learning service offers independant verification of results – details on the monthly MCQ papers. [illegible] to register for Pharmacy Update can contact Mary Prebble on 01732 377269.

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MHRA advises on HRT

The Medicines and Healthcare products Regulatory Agency has issued a statement on the use of hormone replacement therapy.

It says that in women who use HRT for the short-term treatment of menopausal symptoms the benefits of treatment are considered to outweigh the risks.

"Women should be made aware of the increased incidence of adverse effects with long-term HRT use.

"The decision to use HRT should be discussed with each woman on an individual basis, taking into consideration her age, history, risk factors and personal preferences. In addition, an individual's risk and benefits should be regularly reappraised (at least annually) with continued HRT use. Any woman on HRT who is concerned should discuss her own balance of risks and benefits with her doctor."

On the risk of associated stroke, the MHRA says that it is currently updating all HRT product information to reflect the increased risk of stroke following the publication of an article in the *Journal of the American Medical Association*.

With regards to the impact of HRT on dementia and cognitive impairment an expert group of the Committee on Safety of Medicines is reviewing data from the Women's Health Initiative Memory Study.

This study suggested that HRT doubled the risk of dementia in women over 65 and did not prevent mild cognitive impairment. However, women in this study were much older than those using HRT in the UK and using a product that is not available in the UK.

When the CSM's review is complete women and health professionals will be informed of any new advice.

For more information:

www.mhra.gov.uk

The balance of risk should be discussed with each woman individually

A question of patient choice

Patients may choose not to take their medicines, rather than just being forgetful, according to a new report from Medicines Partnership.

A Question of Choice: Compliance in Medicines Taking studied 11 disease areas and says the evidence shows that non-compliance is still a major cause of unnecessary ill health and death.

And despite new medicines being developed that may be easier to take, with fewer side-effects, compliance rates have not improved since a study carried out in 1996, which showed that non-compliance was a serious issue affecting up to half the medicines prescribed for chronic conditions.

Factors associated with poor compliance include:

- complex drug regimens involving multiple doses and several medicines
- unwanted side effects
- concerns about the value or appropriateness of taking medicines
- denial of illness, especially amongst younger people.

The research also highlights the enormous cost of non-compliance at a time of increasing medicines expenditure. Interventions giving patients more information or further instructions were shown to be ineffective in improving compliance but other methods shown to be useful include:

- raising patients' confidence levels and knowledge in managing their treatment
- developing more collaborative relationships between patients and professionals in making joint decisions about treatment
- combining timely, practical help with problems with emotional and peer group support.

Community and other pharmacists are well placed to improve compliance in a wide range of patients, according to section summaries in the report.

For more information:

www.medicines-partnership.org

Scriptlines

Androgen gel launched for men

Schering Health Care will launch a testosterone gel for the treatment of male hypogonadism on Monday.

Testogel, which contains testosterone 50mg per 5g sachet, is indicated for testosterone replacement therapy for male hypogonadism, where clinical symptoms and biochemical tests confirm low testosterone deficiency.

The recommended dose, for adult and elderly men, is 5g of gel to be applied once daily, to the shoulders, arms or abdomen. It should be applied in the morning and the maximum daily dose should not exceed 10g of gel.

Contraindications include cases of known or suspected prostatic cancer or breast carcinoma.

Undesirable effects include application site reactions such as erythema, acne and dry skin. Other adverse effects include headache, prostatic disorders, mastodynia gynaecomastia, amnesia, mood disorders, diarrhoea and alopecia.

Patients must be advised that following Testogel application and if no precautions are taken, there is a risk of testosterone transfer to other persons by close skin-to-skin contact. This can result in increased testosterone serum levels and possible adverse effects.

Price: £33

Pack size: 30 x 5g sachets

Pip code: 294-6978

Schering Health Care

Tel: 01444 232323.

Mysoline to go

AstraZeneca has announced that it will cease production of its epilepsy treatment Mysoline (primidone 250mg) globally due to low volume usage.

The company says that the discontinuation of Mysoline tablets in the UK will take effect from December 1.

For more information:

AstraZeneca

Tel: 0800 7830033.

Duovent Inhaler discontinued

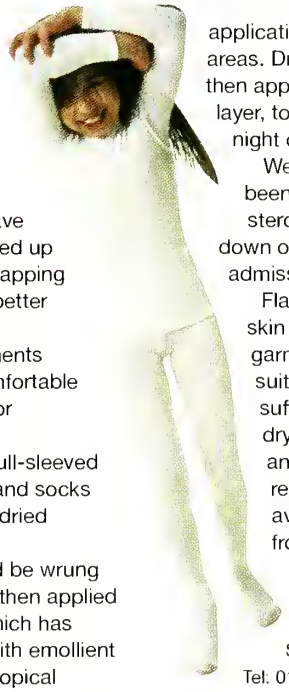
Boehringer Ingelheim has announced that Duovent Inhaler and Autohaler (fenoterol and ipratropium) will be discontinued on August 31. Duovent UDVs for nebulisation will remain available.

For more information:

Boehringer Ingelheim

Tel: 01344 424600.

Tubifast wraps up kid's eczema



A range of ready-to-wear stretch garments is being launched to help parents manage their child's eczema conveniently at home.

Tubifast garments have been developed to speed up and simplify the wet wrapping process, encouraging better compliance.

The lightweight garments are designed to be comfortable to wear beneath night or day clothes.

The range includes full-sleeved vests, tights, leggings and socks which can be washed, dried and re-used.

The garments should be wrung out in warm water and then applied damp onto the skin, which has been liberally coated with emollient and with a prescribed topical application on badly affected areas. Dry garments are then applied as a second layer, topped by normal night or daytime clothes.

Wet wrapping has been proved to reduce steroid usage and to cut down on hospital admissions.

Flat seamed to prevent skin irritation, the garments are also suitable for eczema sufferers following a dry wrapping regime and for dressing retention. They are available in five sizes from six months to 14 years.

Price: from £5.00 to £20.00

SSL International Plc
Tel: 01565 625000.

Soft option for scars

ICN Pharmaceuticals is launching an OTC topical silicone gel for the management of scars and the prevention of abnormal hypertrophic and keloid scars.

Dermatix is a non-invasive silicone liquid gel designed to offer a cost-effective alternative to painful corticosteroid injections.

It is formulated to soften, flatten and smooth scars as well as reduce discolouration, pain and itchiness.

The gel is suitable for highly visible and difficult to treat locations such as the face, extremities and joints.

It is odourless, colourless and self-drying. Cosmetics can be applied after application.

The product is suitable for patients of all ages, including children, and can be used on both old and new scars. It should be applied twice daily for two months.

Price: £39.99

Pack size: 15g tube
Pip code: 293-4206
ICN Pharmaceuticals Ltd
Tel: 01256 707744.

Peanut-free nappy cream

Weleda has reformulated its Calendula Nappy Change Cream as a peanut-free product.

The new formula is a deep nourishing barrier cream containing calendula and chamomile with almond oil instead of peanut oil.

The change comes as a result of enquiries from parents and health professionals questioning the use of peanut oil (arachis oil).

A display outer containing 12 75ml packs is available for £28.32.

Price: £4.95

Pack size: 75ml
Pip code: 205-1514
Weleda (UK) Ltd
Tel: 0115 9448237.

Worn out from life's juggling act

Over 80 per cent of people describe themselves as 'tired', 'stressed' or 'knackered' on a daily basis according to new research.

The 'Life's a Circus' survey, which was commissioned for Pharmaton Capsules, highlights the demands than modern life places on us, leaving the nation exhausted. Only 7 per cent of respondents reported feeling 'energised'.

Boehringer Ingelheim believes the results indicate the opportunity for pharmacists to capitalise on the daily fatigue sector.

The company says that with 74 per cent of sufferers not treating, access to education and information within the pharmacy arena is essential.

Pharmaton is now the number one brand in the energy market with a 42 per cent share of the pharmacy market (Information Resources April '03).

For more information:

Boehringer Ingelheim
Tel: 01344 741493.

Gel range comes from Harley Street

Harley Street Cosmetics is a new range of homoeopathic gels developed by the founder of the cosmetic surgery 'Laser Clear' in Harley Street.

The range includes 10 essential oils – arnica, calendula, comfrey, evening primrose, green tea, lavender, neem, myrrh, tea tree and witch hazel.

Formulated to be absorbed easily into the skin, the gels are suitable for those who suffer from sensitive skin or from minor skin complaints.

All the products contain a 10 per cent concentration of herbal extract with 11 per cent aloe vera. Honey and grapefruit seed extract are used as natural preservatives.

The gels contain no artificial colourings, chemical preservatives or synthetic perfumes.

Price: £12.00

Harley Street Cosmetics
Tel: 0800 252 875.

Best foot forward

Foot Vitality is a new range of four footcare products from J Pickles Healthcare.

Foot Odour Solutions is a two-stage treatment to leave the feet deodorised. The kit comprises three deodorising foot bath salts and six cleansing foot wipes.

Refreshing Foot Gel is an energising gel containing aloe vera and extract of horse chestnut to condition the skin and an antibacterial agent to help control foot odour.

Rough Skin Remover contains exfoliating granules and fruit acids to remove hard and rough skin. It is suitable for use on the knees and elbows as well as the feet.

Softening Lotion is a light, easily absorbed lotion containing wheatgerm oil and evening primrose oil.

Research shows that eight out of 10 adults suffer from a foot problem and women are four times more likely to be affected, mainly because of badly fitting footwear.

Price: Odour Solutions £4.99, Foot Gel and Rough Skin Remover £3.49, Softening Lotion £2.75

Pip code: Odour Solutions 290-1403, Foot Gel 290-1437, Rough Skin Remover 290-1411, Softening Lotion 290-1429

J Pickles Healthcare

Tel: 01423 796934.

Atchoo! Aller-eze hits the road to catch travellers

Aller-eze takes to the road this month with a novel approach to catching bus travellers' attention.

From June 17-30, bus stop poster sites in major towns across the country will literally 'sneeze' as they communicate details of Aller-eze.

An automatic pre-recorded audible sneeze has been fitted to the sites, which will operate throughout the day.

The advertising campaign will also appear on bus tickets and bus side posters from June 9 until July 6.

The posters feature one of the biggest causes of summer hayfever suffering – grass pollen – combined with the Aller-eze message that 'one spray relieves hayfever all through the day.'

The campaign is part of a £1.25 million summer marketing programme for the brand.

For more information:

Novartis Consumer Health

Tel: 01403 210211.

Vichy's night-time partner

[illegible] partner to the Vichy [illegible] cream will be [illegible] with Phyto-[illegible] Saphenone is a rich [illegible] for the face and [illegible] been developed to [illegible] ing skin creasing [illegible] plus.

The [illegible] laboratory says that 86 per cent of women claimed morning skin creases were visibly smoothed after three weeks of daily application of the product.

Presented in a transparent jar, the sea green coloured cream contains plant oils and has a fresh green tea fragrance. It is suitable for all skin types.

Price: £17.50

Pack size: 50ml jar

Pip code: 297-0184

Cosmetique Active (UK) Ltd

Tel: 020 8762 4030.

Read the signs

Superspecs is introducing a new display package for the Décor range of reading glasses.

An eye-catching display stand has a brushed aluminium style column and frosted shelves.

It is supplied with seven of the latest designs of ready-made Décor reading glasses.

Costing £325.50, the package comprises 78 reading glasses, cases and spectacle cords.

For more information:

Direct Perceptions Ltd

Tel: 020 8551 1315.

Wella 'shocks' it to them

Wella Shockwaves will hit the radio airwaves this week with a humorous radio advertising campaign targeted at the brand's unisex 16-24-year-old market.

Using the distinctive voice of comic Viv Reeves, the commercials feature unfeasibly bizarre ways to style your hair while offering Shockwaves as the alternative.

The campaign will run on leading youth radio stations from June 9 until December.

For more information:

Wella Great Britain

Tel: 01256 320202.

Allergy advice on the web

The Benadryl website is being relaunched to provide access to latest pollen forecasts compiled by the Allergy Alert Network.

The interactive website offers advice on hayfever, dust allergy, pet allergy and skin allergy. There is an opportunity to request specific information on-line plus the chance to win exciting prizes in various competitions.

Subscribers can have regular pollen forecasts sent to them via SMS or email to their mobile or PC.

For more information:

www.allergyadvice.co.uk

TV next week

Accu-Chek Compact blood glucose meter: All areas except C4

Aqua Ban: GMTV

Aquafresh: All areas except U, CTV, GMTV

Bodyform: U, STV, C, HTV, W, LWT

Flixonase: All areas except U, CTV, GMTV

Kalms: Sat E4

Listerine: All areas

Lucozade Sport: All areas except U, CTV, GMTV

Piriteze: All areas except U, CTV, GMTV

Piriton: All areas except U, CTV, GMTV

Pro Plus: C4, C5,

Ribena Toothkind: All areas except U, CTV, GMTV

Solpadeine: Sat

Tena *lady* & Tena *pants* Discreet: All areas except U, GMTV

PharmaSite for next week: Clarityn – window, **Clarityn** – in-store, **Clarityn** – dispensary

A-Anglia, B-Border, C-Central, C4-Channel 4, C5-Channel 5, CAR-Carlton, CTV-Channel Islands, G-Granada, GMTV-Breakfast Television, GTV-Grampian, HTV-Wales & West, LWT-London Weekend, M-Meridian, Sat-Satellite, STV-Scotland (central), TT-Tyne Tees, U-Ulster, W-Westcountry, Y-Yorkshire

the dawn of a new era for *Pancreatitis* sufferers...

Antox™ vers1.2 **NEW DOSE**

Food for special medical purposes.

For the dietary management of chronic pancreatitis.

Each tablet contains: 50mcg selenium (High selenium yeast), 480mg L-methionine (L-seleno methionine) 20mg Vitamin C (ascorbic acid), 38mg Vitamin E (a-tocopherol acetate).
Indications: For the nutritional management of chronic pancreatitis
Recommended daily intake: Adults, 1-6 tablets daily (with maximum dose 2 tablets 3 times daily).
Contra-indications: Hyper sensitivity to any of the ingredients, renal insufficiency. Do not use in suspected cases of schizophrenia
Interactions with other medicaments: There is no evidence from clinical experience that Antox™ ... tablets interact with other medication
Pregnancy and Lactation: Multivitamin and mineral preparations of this nature have not been shown to have teratogenic effects or effects on fertility.
Overdose: Toxicity of this product in huge doses is not considered to be life threatening. Conservative nursing and advanced hydration may be required
Legal Category: Medical Food - Food for special medical purposes. To be provided on a named patient basis only by prescription from a registered medical practitioner
Further information on Antox is available on request from: Pharma Nord (UK) Ltd, Telford Court, Morpeth NE61 2DB Tel: +44(0)1670 519989 Fax: +44(0)1670 513222 or fill in coupon.

Pharma Nord

NAME: _____

ADDRESS: _____

POST CODE: _____ TEL No: _____

A charity case?

The RPSGB is considering seeking charitable status. Greyham Dawes, a director of the Charities Unit at Horwath Clark Whitehill, the Society's professional auditors, discusses the pros and cons

What are the five key pros and cons of taking up charitable status for an organisation that exists under a charter?

The key advantages, which are just the same for chartered charities, are:

- ✔ exemption from income/corporation tax, capital gains tax and stamp duty;
- ✔ donors' gifts/bequests to charities are fully deductible for inheritance tax on their estate;
- ✔ there are valuable tax incentives to donors for gifts of land and quoted securities to charities, as well as gift aid tax relief for both the individual donor and the charity for cash gifts (ie other than membership-benefit subscriptions) or for the corporate donor (eg a profitable trading subsidiary) for its cash gifts to the charity;
- ✔ because of their public-benefit commitment, charities can appeal for voluntary funding from the public, as well as from grant-making trusts and foundations, more easily and credibly than can non-charitable bodies;
- ✔ charities are entitled to at least 80 per cent business rates relief on the buildings they occupy to further their charitable purposes, with a further 20 per cent at the discretion of the local authority.

The key constraints on charities

are again no different for charter bodies:

- charities must have exclusively charitable purposes, and any activities above the minimum statutory limit of up to £50,000 turnover that do not fall within those purposes have to be hived off into a separate non-charitable organisation – most charities use a controlled trading company through which to conduct the non-charitable trading activities upon which they rely for a tax-efficient income stream, usually by means of gift aid donations made under a profit-stripping covenant. The Charity Commission guidelines on this are on its website publication *CC35: Charities and Trading.*
- the extent of political or campaigning activities which a charity can take on are limited to those deemed non-party political – the Charity Commission guidelines on this are given on its website publication *CC9: Political Activities and Campaigning by Charities.*
- charity trustees are not allowed to receive financial benefits from the charity which they manage except to the extent specifically authorised in the charter or by the Charity Commission. Financial benefits include salaries, services, or the awarding of business contracts to a trustee's own business from the charity. Benefits which are incompatible with the establishment of an organisation for exclusively charitable purposes cannot be authorised at all. Further guidance can be found in *CC11: Payment of Charity Trustees.* There are similar problems where the spouse, relative or partner of a trustee receives such benefits. This does not, of course, stop charity trustees being reimbursed for their reasonable out-of-pocket expenses of attending to their duties as trustees – as long as these expense claims do not include any element of unauthorised personal profit to the trustee or a connected person.
- trustees have a charity law duty not to let their personal interests conflict with their charity law duties, and this requires the charity to have adequate conflict-management procedures in place to deal with any potential conflicts.
- charities have to comply with their public accountability obligations under the Charities Act 1993 in accordance with the Charities SORP as required by the related regulations under that Act, and they have to submit to statutory monitoring by the Charity Commission as the official regulator responsible to Parliament for the protection and proper application of the sector's charitable resources.

It is worth pointing out that the 'cons' part of the answer are constraints – not 'disadvantages'.

Can a professional body, which is politically active in representing its members and which takes profits from a commercial business, take up charitable status?

Yes – provided the political activity is not party-political and the profits are received as a gift or an investment dividend (eg from a wholly owned subsidiary trading company) and not from running a business within the charity itself.

What is the definition of public interest, as in for a charitable purpose? Is this a legal definition or is it decided by the Government and is it open to interpretation?

What is meant here is 'the common good', as distinct from private interests – except that there can be a minor element of the latter as long as it is only ancillary to the former and does not outweigh it. The concept is a common law definition arising, not a statutory one. The courts and the Charity Commission interpret it by analogy with 'precedents' established by decided cases not since overruled by a higher court or overridden by statute law.

What happens to a body's assets when it (a) takes up charitable status and (b) relinquishes charitable status?

From point (a) onwards any distribution of that body's assets to members by way of private profit or gain is prohibited by charity law, while at point (b) the assets will not be lawfully available for private distribution except to the extent of any corporate property held prior to point (a) but will be regarded as trust property for the charitable purposes declared at point (a) and held either by the body itself as trustee or, as authorised by law, by some other willing trustee or for transfer to a charity having the same or similar purposes.

Why is the Government currently revamping the Charities Act, and what are the implications of this?

It is not a 'revamping' of the existing Charities Acts that is currently under consideration but changes to streamline and enhance the regulation of the sector by the Charity Commission, together with a new Charities Bill to deal with certain matters that it was not possible to legislate for in those Acts at the time. These changes do not appear to have any adverse implications for charities that are properly administered with due care by their trustees.

The Home Office Bill for the new recommended legislation is expected to introduce:

- a statutory definition of charitable purposes based on society's current needs and set out under 10 headings instead of four
- abolition of the traditional common law presumption in favour of education, religion and the relief of poverty as 'public benefit' purposes
- performance reporting in a standardised format by the largest charities (approximately 2,500 – those exceeding £1million annual gross income) as part of their annual report and accounts
- introduction of a statutory duty of care to take the place of the existing restrictions on non-charitable trading by charities
- structural reform of the Charity Commission to give more weight to its regulatory functions, and a number of other matters as set out in the Cabinet Office Strategy Unit's report of 2002.

What is the application process for those seeking charitable status, how long does it take and is it costly to undertake?

Applications for registration with the Charity Commissioners for England and Wales require completion and submission of a standard application form *APP1* describing the organisation's declared objects and its actual or proposed activities and providing certain administrative information needed for registration and monitoring purposes. This is in addition to a declaration signed by all those who are to be recorded as the charity trustees at the time of registration, with supporting documentation including certified copies of the charter or other governing document. This is to enable the Commissioners to decide whether they can properly register the organisation as a charity under English law.

The Commission's target for this process is 90 working days and it is free, so the only major costs are accountancy, legal, and other professional services, plus internal costs from undertaking any constitutional and/or organisational changes considered advisable in the circumstances.

An eye-opening

A group of pharmacists on the south coast are helping customers treat eye infections by supplying antibiotics OTC – much to everybody's satisfaction. Vanessa Sherwood reports

A couple of years ago 10 keen pharmacists in the Adur PCG district came up with the idea of supplying chloramphenicol eye drops via patient group direction (PGD). After approaching local GPs who also approved of the idea, the PCG pharmacist at the time set about establishing the scheme. This included gaining the approval of the microbiologist at the local NHS trust who was happy for the scheme to go ahead, despite having turned down previous requests for the supply of other topical antibiotics.

Sam Scragg, prescribing support pharmacist for the now Adur, Arun and Worthing PCT, who manages the scheme, says PGDs should be used where there is a clinical need for the product and where it improves patient access. "With the appointments system the way it was, this was seen as a good use of current resources to provide a treatment to patients on the day they needed it. The main selling points were that it increased access, provided a service that wasn't already available and was using a product that GPs use to treat the condition anyway," she says.

Any concerns about resistance have been addressed by strictly limiting the conditions that chloramphenicol can be used for (*see below*).

Training

Pharmacists attended a training evening led by a GP with a special interest in ophthalmology, with input from the microbiologist and prescribing adviser. They also had to complete the Centre for Pharmacy Postgraduate Education's distance learning programme *Pharmaceutical Care of the Eye*.

Before being accepted on to the scheme pharmacists had to be satisfied that they could meet the accreditation requirements including being able to identify:

- bacterial conjunctivitis
- the principal effects of topical chloramphenicol
- the principal contraindications of topical chloramphenicol
- the factors that would influence the choice of drops or ointment
- the typical appearance of a local allergic reaction to topical chloramphenicol.

Payment

All patients have to fill in a declaration form, similar to the back of a prescription, confirming that the information they have given to the pharmacist is correct and that they are willing to accept treatment from the pharmacist. Patients who are exempt from prescription charges declare this in the normal way on the back of the form and others pay the prescription charge.

Pharmacists are paid £5 per consultation if they supply the chloramphenicol but are not paid if they decide that the patient doesn't need the treatment or if they are referred to the GP. The PCT then pays pharmacists monthly.

Stuart McMillan, pharmacy manager at Martin's Pharmacy, Southwick, is happy with the fee level. "It's fairly quick and easy and there's not too much paperwork," he says.

"Most people are happy to pay the £6.30 charge, accepting that it's more effective than the slightly cheaper OTC preparations." Mr McMillan thinks it would be useful to have PGDs developed for other antibacterials such as three-day courses of trimethoprim for urinary tract infections and creams such as Bactroban. He says that operating the scheme has also improved working relationships with the local GP surgery and he would recommend it to other pharmacists.

Miss Scragg would also recommend PGDs to other PCTs

scheme

and pharmacists but warns that they are not to be taken lightly. "They do involve an awful lot of work," she says. "It's important to involve community pharmacists, as ideally it should be their idea and something they see that they can do to help meet PCT priorities whilst addressing the needs of patients.

"Apart from that, if you've got an enthusiastic group of people who are willing do a bit of extra work then community pharmacists are an invaluable resource to increase access for patients. We could utilise community pharmacists more and PGDs are one way to do that."

Sample PGDs are available at *www.groupprotocols.org.uk*. For more information e-mail *samantha.scragg@aam.nhs.uk*

Digital help for diabetic eyes

It is hoped that more than 1,000 people a year with diabetes could be prevented from having impaired sight, or even going blind, with the introduction of digital retinopathy cameras.

Earlier this year, health minister David Lammy announced that £27 million will be spent over the next three years to purchase the equipment. The cameras will provide precise digital images of the eye that can be compared over time to track changes in the retina that provide doctors with an 'early warning' of any deterioration in the patient's eyesight. Diabetes is the leading cause of blindness in adults of working age.

Eyecare a low priority

Despite an increasing interest in health and wellbeing, people are still not looking after their eyes, according to a survey by Vitabiotics, manufacturer of Visionace.

The survey of 500 people revealed that:

- 27 per cent of people admitted that eyecare was not a health priority
- 54 per cent had not had an eye test in the last three years
- only 3 per cent knew that eye tests can pick up age-related macular degeneration and 27 per cent knew eye tests can detect diabetes.

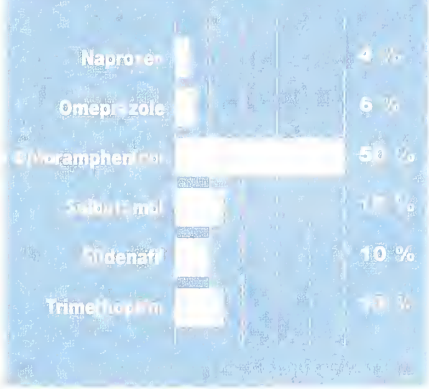
Age-related macular degeneration is the leading cause of blindness in people over 65 in the western world, with at least 500,000 sufferers in the UK. For most sufferers there is no treatment. Dr Frank Eperjesi, a research optometrist at Aston University, recently described AMD as "a devastating disease".

AMD is caused by a build up of natural metabolic waste products and free radical damage in retinal cells. This leads to a loss of central vision although peripheral vision is unaffected. AMD can be detected via an eye test from as early as 40 years old. However, as there is no treatment, people may not be told they have the condition.

Risk factors for AMD include: age, smoking (including passive smoking), alcohol, poor diet, heavy sunlight exposure, being female, family history, light iris colour and heart disease.

Dr Eperjesi said that nutritional supplements designed specifically for the eye are "very likely" to prevent or delay sight-threatening eye diseases such as AMD, and also glaucoma and cataracts. Supplements containing the antioxidant lutein protect against AMD by increasing the pigmentation in the macula, protecting against free radical damage. Lutein is also found naturally in dark green leafy vegetables such as spinach and kale.

The Government has set a radical agenda to increase the number of products available for consumers to purchase. By 2007, the plan is to have another 50 POM to P switches. Last year's *C&D* Question Time poll *(June 22, 2002, p6)* asked pharmacists which product they would most like to see made available over the counter. The results were:



Dry eyes

Around 50 per cent of office workers complain of dry eye related problems. When there are not enough tears to lubricate the eye, or the tears are of poor quality, symptoms of dry eyes include stinging, burning, 'scratchiness' and general discomfort.

Air conditioning and central heating are well-recognised causes of dry eyes but the increasing use of computers may also cause dry eyes. Staring at a VDU can reduce the blink rate from 20 to five blinks per minute, reducing lubrication.

Dry eyes can also account for 30 per cent of drop-outs from contact lens wear.

Continued on page 34

UK patients suffer in silence

New research shows that a third of people with hearing loss wait for more than two years before seeking medical help despite it having a serious impact on personal relationships and social lives.

The survey, undertaken by Defeating Deafness (the hearing research trust), and sponsored by Boots Hearingcare, raises concerns that a reluctance to see their GP could be putting people at risk of long term hearing damage.

Only 14 per cent of those questioned in the survey had sought medical help immediately. The most common reason for not seeking help is because patients do not think their problem is serious enough to bother their GP with. However, 40 per cent of people said they had problems communicating with their partner and nearly one in four had to miss out on social events as a result of their hearing loss.

Vivienne Michael, chief executive of Defeating Deafness, commented: "The earlier hearing loss is diagnosed the quicker something can be done about it. This may be through identifying and treating the primary cause of the problem or by allowing the early prescription of a hearing aid."

The research also aimed to find out what improvements patients with hearing loss would like to see when it comes to services and aids. The majority of respondents (42 per cent) said they would like better quality hearing aids. Other improvements included better access to information and hearing tests, quicker referral to NHS audiology services, better understanding and awareness of hearing loss by GPs and less expensive private hearing aids.

Vivienne Michael says: "The fact that many people are reluctant to consult their GP and suffer in silence for longer than necessary indicates that hearing loss is still regarded as a taboo subject. This means that more public education is needed to encourage people to act promptly about their hearing loss, especially if they are to avoid any further hearing damage."

An estimated 8.7 million people in the UK have some degree of hearing impairment. According to the National Institute for Clinical Excellence (NICE), around 10 per cent of the adult population could benefit from hearing aid services but are either unwilling to use them, or do not access them because their hearing loss remains undetected.

At the end of March, the eyecare market in chemists, inc. Boots, was worth £29,683,000 – an increase of 3 per cent on the same period last year.

Top five brands (excluding hayfever products)

- Brolene
- Optrex
- Optrex Fresh Eyes
- Golden Eye
- Eye Dew Blue

Only 22 per cent of eyecare sales are in the grocery sector, the remaining 78 per cent of sales are in pharmacy.

The nearly £30 million of sales above are divided as

- drops, £19m, growing at 6 per cent
- solutions, £4.9m, static
- ointments, £4.8m, static
- masks, £0.9m, declining 23 per cent.

In the grocery sector, the total eyecare market is valued at £8.7m, growing at 4 per cent year on year, with drops accounting for £6.5m of total sales, growing 12 per cent.

Eyes on the market

Brolene is brand leader in the infected eyecare market, with 75 per cent of value share according to IMS. However, despite a third of customers asking for Brolene by name there may be some who are still not treating eye infections appropriately.

Research commissioned by Aventis shows many people still purchasing simple eye wash preparations when antibacterial drops or ointment would be more effective. Chemist Brokers, tel: 023 9222 2500.

Last summer, Opticrom Allergy Eye Drops, continued to lead the way in hayfever eye sales with market share growing to 64 per cent, according to IMS (October 2002).

The only non-prescription for children over six years old, these drops, containing sodium cromoglicate 2 per cent w/v, help to relieve redness, itching and watering of the eyes due to all allergies, making them suitable for year-round use. Chemist Brokers Healthcare Division, tel: 023 9222 2500.

Following the successful launch of Alomide eye drops into pharmacies last year, Alcon will be promoting it again this year via wholesaler special offers.

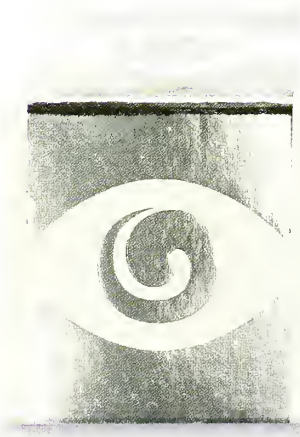
Alomide, containing lodoxamide 0.1%, offers advantages over the current market leader, sodium cromoglicate 2 per cent, as it is more effective at relieving hayfever symptoms, according to Alcon. Lodoxamide not only stabilises mast cells but also helps to inhibit histamine release, helping to block the allergic response.

Mentholatum is not a name that pharmacists would traditionally associate with eyecare but, as manufacturer of ROHTO V and ZI eye drops, the company is starting to compete in the eyecare market.

Although there are no new product developments planned for the remainder of this year the company hopes to build on the profile of ROHTO V eye brightening drops which were launched at the end of 2001. ROHTO V already has 5 per cent of the brightener category.

Aventis

ANT_ _NFECT_VE



Brolene®
For the Treatment of Minor Eye Infections

Brolene®

For the Treatment of Minor Eye Infections

Thank you for putting in the eyes

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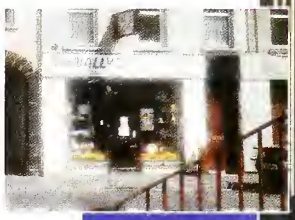
ences: 1. IMS October 2002 2. NOP November 2001

ENE™ **PRESCRIBING INFORMATION** **Presentations**: Eye Drops containing Propamidine Isethionate 0.1% w/v. Eye Ointment containing Dibromopropamidine Isethionate 0.15%. **Indications**: Treatment of minor eye infections. **Dosage & Administration in Adults (including the elderly) and Children**: Eye Drops: One or two drops applied topically up to four times Eye Ointment: Apply once or twice daily into the eye. **Contraindications**: Hypersensitivity to ingredients. **Precautions and Warnings**: Blurring of vision may occur on instillation. Patient l not drive or operate machinery until vision is clear. If vision becomes disturbed, symptoms become worse or no significant improvement occurs after two days use, treatment should be itinued and medical advice obtained. Eye drops are unsuitable for use with hard or soft contact lenses. **Pregnancy**: Should not be used during pregnancy or lactation unless considered ial by a physician. **Adverse Effects**: Hypersensitivity. **Legal Category**: P. **Pharmaceutical Precautions**: Store below 25°C. Eye drops should be discarded 28 days after first opening rs in hospital). Eye ointment should be discarded 28 days after opening. **Eye Drops** Retail Price £4.49 PL No 04425/0197. **Eye Ointment** Retail Price £4.69 PL No 04425/0198 of Preparation: March 2003. Further information is available from Aventis Pharma Limited, 50 Kings Hill Avenue, Kings Hill, West Malling, Kent ME19 4AH.

Brolene
dibromopropamidine isethionate
The best selling treatment for minor eye infections[1]

Facing up to change

A DIY shop front helped a Northern Ireland pharmacy win an award in the *C&D* Platinum Design Awards, sponsored by Ceuta Healthcare



The old shop front (above) and the new shop front, which won plaudits from the judges in the *C&D* Platinum Design Awards, sponsored by Ceuta Healthcare

The C&D Platinum Design Awards are sponsored by Ceuta Healthcare and recognise excellence in pharmacy shopfitting and design. The next Awards will be announced in September and will be open to any pharmacy refitted between January 2002 and December 2003.

For most of us the phrase "a DIY job" conjures up images of botched work by an enthusiastic amateur – gaping windows, dodgy wiring and sloping shelves. To hear a pharmacy owner proudly describe her shop front as "a DIY job" might raise concerns – until you see the final result, that is.

Marian Hamill is rightly proud of her pharmacy, and particularly her shop front, since she and her husband designed it themselves. The judges at last year's *C&D* Platinum Design Awards thought it was pretty good too, and awarded her the top prize in the 'special feature' category.

Hamills Pharmacy in Portadown, Co Armagh, used to be a small place at the bottom end of the town. In 1993 a bomb badly damaged the building, which had to be demolished. Within five days the pharmacy had re-opened next to its present location, about 100 yards off the High Street in Thomas Street.

[illegible] (right) and her four staff at [illegible] counter

It was five years, though, before Mrs Hamill was able to persuade the man who owned next door to sell. When he eventually did so, she had very firm ideas about how her new property was to be developed.

"I don't like pigeon holes, hatches and steps up to the dispensary ... I wanted to keep the shop area open and make the dispensary bigger. I consciously went for 60 per cent dispensary and 40 per cent front shop.

"There is a semi-private area in front of the dispensary to the side of the medicines counter. It's next to a private consultation room, but that is deliberately not signposted because it means I can control who warrants a consultation and who does not."

"I don't like pigeon holes, hatches and steps up to the dispensary"

In another life Mrs Hamill might have enjoyed a successful career as an interior designer, given the dedication with which she pursued her objective. With her husband, Malachy, she scoured Ireland – north and south – for ideas.

"I had Wednesday's off, and for 30 Wednesday's over the course of a year we went and looked at other pharmacies for ideas. It got to the stage I could recognise who had fitted out which shop. I wanted something warm and welcoming. I did not like blues and modern looks that would date."

Retail Review, a Belfast shopfitter now renamed Xevala, was the company most in tune with her ideas, and won the contract for fitting out the pharmacy. The company's Patrick McKeever diplomatically describes her as "a challenging customer".

When he arrived with light fittings for the front shop – "great big blobby things like fly traps", according to Mrs Hamill – they were shown the door. Instead she had lampshades custom-made by a man she found in Belfast.

Attention to detail is evident elsewhere. All the counter tops are polished granite. "I did not want something that would get scratched and scored in a few years' time," she says. The shopfitters installed white plug sockets: they have all been changed to brass.

It is now two years since Professor David Jones from Queen's University officially opened the refitted pharmacy. Counter business has risen by 40 per cent, mostly in P medicines. Mrs Hamill says she does not want to change anything. As far as she is concerned the £50,000 cost of fitting out the premises, and £5,000 for the shop front is money well spent.

"The shop front is only five metres wide. What do you do with that? I wanted a double door for access. I wanted a healthcare image. I wanted people to be able to see into the shop. I wanted people to notice the

The Millennium Design Awards are sponsored by

CEUTA HEALTHCARE GROUP of COMPANIES

pharmacy as they drove past."

Her forays across Ireland eventually delivered a solution. "We did not see anything we liked for ages until we came across a jeweller's shop in Co Cork, way down south."

Her husband, a research engineer in the aerospace industry, drew up the plans, designed the lighting and the stained glass panels, and specified the materials.

The 1.6m on either side of the double doors houses curved laminated safety glass in mahogany frames. Pharmacy emblems in stained glass are installed in fanlights across the top of windows and doors. A local craftsman created the stained glass "in a shed at the bottom of his garden". The job cost £1,000, which Mrs Hamill still considers a bargain.

A traditional fascia, with the pharmacy name emblazoned in gold, hides a roller shutter. Door fittings and kick plates are in brass (regularly polished, of course!)

Thomas Street is not exactly a retailing hot spot, but there are two other pharmacies further up the road, attracted by a 'pot of gold' a quarter of a mile away – a health centre housing 22 GPs. Not surprisingly 95 per cent of the pharmacy's turnover comes from NHS business.

Marion Hamill has owned the business since 1990. She used to do locum work for the previous owner, Jim McNally. He died suddenly and Mrs Hamill ran the pharmacy for his wife. She twice turned down proposals that she should buy it before taking the plunge.

Front shop stock is minimal away from the medicines counter. Toiletry, baby and natural medicine lines fill what little shelving there is. The stock room is a small enclave at the rear of the dispensary, which is huge. Six stand-alone shelving units lead, two by two, to the rear of the pharmacy, with a wet preparation area and dispensing bench to one side, and stock bays on the other.

One bay, stacked floor to ceiling with dressings, would not look out of place in a hospital pharmacy. Mrs Hamill has carved out a profitable niche as a supplier to local district nurses.

Above: Marian Hamill in the dressings section of the dispensary

Right: Marian wanted to keep the shop area open and make the dispensary bigger. She aimed for a warm and welcoming style rather than a more stark, modern look which she felt would date more quickly

AAH rolls out Health Watch

'Defining the path for pharmacy' was the theme of the AAH Convention which took place this week in California. The focus was how pharmacists could best manage the multitude of changes they currently face. Patrick Grice reports

California 2003

AAH's medicines management programme is being launched to all Vantage customers under the Vantage Health Watch brand name. The programme has been piloted in 25 pharmacies over the past year.

It provides a turnkey solution that will allow community pharmacists to quickly introduce medicines management programmes. Every pharmacy in Britain is expected to be offering such a service by 2004 according to the Government's *Pharmacy in the Future* strategy, "and that's only seven months away", said AAH's marketing director, Dr Mandeep Mudhar, who developed the programme.

Vantage Health Watch is a four-part proposition which includes:

- a specialist field support team provided by Ceuta
- a local PR and marketing support programme
- a marketing services package including posters, merchandising support and leaflet displays.

These elements come at a cost of £240 per annum. For a once-only payment of £50-£60 pharmacists can buy service packages covering BP monitoring, weight management, smoking cessation and traveller's health. The fourth element is medicine review services for diabetics, older people, CHD and COPD, with many more to come, said Dr Mudhar.

There is a cost to the programme because it has real value, he said. "Look at our weight management or traveller's health programmes, and tell me if there is anything better in the UK," he challenged.

Pharmacists providing "tier two" services under the new contract, due to be introduced next year, will be paid on the basis of the service provided.

"We will make sure VHW services are recognised in this capacity," pledged Dr Mudhar. Money can also be earned by charging customers a fee for services.

"What we strongly recommend is that patient records are kept on all patients who visit the pharmacy as this will provide a good case for payment when funding becomes available. It's more paperwork, but the ultimate benefits are immense."

"We strongly recommend that patient records are kept"

Mandeep Mudhar

Why medicines management?

- £1billion of medicines are wasted every year in the UK, £100 million being unused medicines returned to pharmacies.
- Up to 10 per cent of hospital admissions are directly due to people not taking their medicines properly.
- People are living longer and putting more pressure on the health service. It is estimated that NHS costs will double in the next 10 years if these issues are not addressed.

Impact of supermarket pharmacy still unknown

"The delivery of pharmacy services from non-specialist outlets such as supermarkets is a major structural change within the sector, the impact of which has not yet been fully understood," according to AAH group managing director Steve Dunn.

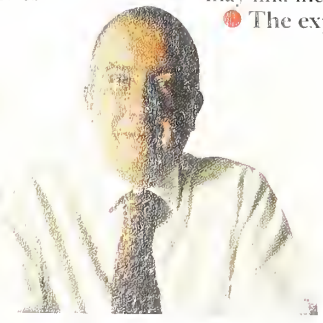
With pharmacy chains still growing and the "unresolved issue" of what happens next after the OFT report, it is vital that all those involved in the pharmacy value chain are clear about the path necessary to confront the future, he said.

Despite the rapidly changing strategic [illegible] community pharmacy will continue [illegible] positive, quality driven and [illegible] in the delivery of healthcare [illegible] AAH Convention. He [illegible] pointers to [illegible] path for pharmacy in the future:

- **Population** – people over 65 make up 16 per cent of the population, rising to 20 per cent by 2010 and this group consumes a larger proportion of medicines expenditure than any other.
- **Technology** – electronic health records will be introduced and electronic prescribing will become the norm. Telemedicine will make its debut. Pharmacies may link incoming ETP to dispensing robots.
- **The expert patient** – government policy encourages people to take greater responsibility for their own health, and there will be continued pressure to deregulate medicines (POM to P).
- **Medication errors** – an increasing risk area for pharmacy. Among the elderly as many as 30 per cent of hospital admissions are due to the adverse effects of medicines. Clinical negligence litigation will grow.
- **The NHS agenda** – PCTs with real muscle and budgets will have an impact on remuneration. There will be an increasing focus on quality, in both setting standards and in service delivery. There probably won't be any more money in the drugs budget. The two-tier contract will see a shift to remuneration for services rather than a fee per item. Repeat dispensing services will become the norm. The extension of prescribing rights may allow pharmacists to take on this role.

[illegible]

[illegible] Dunn



US pharmacy workforce overstretched

There are five schools of pharmacy, 27,000 pharmacists and 29,000 pharmacy technicians in California, and it is not enough.

Drug costs in the USA as a percentage of health expenditure more than doubled between 1993 and 2000 to $112.1 billion, and reached 8.5 per cent of health costs in 2000. The number of prescriptions dispensed has increased by 44 per cent to 2.8 bn over the past decade.

This growth has put severe pressure on the pharmacy workforce. In the latest national survey of American hospitals, 94 per cent of respondents said there was a shortage of pharmacists in their area. It has been the expansion of pharmacy services into supermarkets that has had the most effect on competition. These employers not only pay an average of $6,000 per year more than hospitals but also provide services for up to 24 hours a day. The average pharmacists' salary in the USA is $62,510 but can go as high as $90,000.

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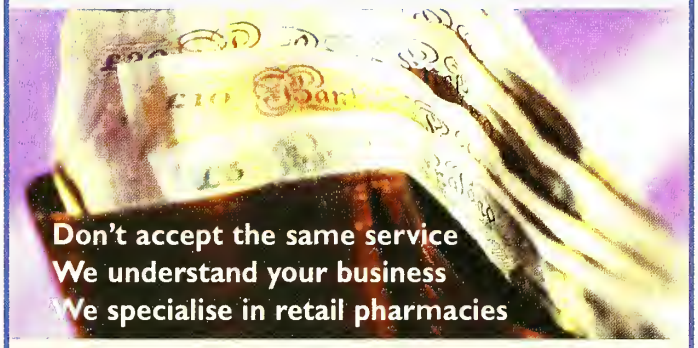

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Chemist & Druggist's web site – *www.dotpharmacy.co.uk* – has introduced a service that offers pharmacists free legal advice from a leading solicitors' firm.

The service – dotLaw – is being run with the co-operation of Charles Russell, whose specialist legal fields include pharmacy matters.

Pharmacists are advised to e-mail their questions to – *pharmlaw@cmpinformation.com* – along with their full name and the name of their pharmacy. The latter two details are for *C&D*'s records only – pharmacists' identities will be kept anonymous when the answers are published.

All the questions and Charles Russell's replies, which will be available in two working days, will appear on a new dotPharmacy page called dotLaw.

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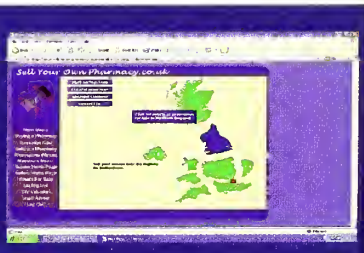

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Terry Scicluna


Duncan Craig

Professor Duncan Craig has been appointed as head of pharmacy and chair in pharmaceutics at the University of East Anglia. Professor Craig joins from Queen's University, Belfast. Professor Andrew Thomson, dean of the School of Chemical Sciences, described Prof Craig as "one of the rising stars of the new generation of pharmacists in the academic profession".

Moss Pharmacy has announced that **Terry Scicluna** is the new operations director for the company. He has more than 20 years' experience in the retail and logistics sector including appointments as managing director for Radio Rentals, DER Direct and Easiview Thorn UK. He said: "I am optimistic that with the many years of experience across other retail sectors I can ensure a fresh and innovative approach building on the great work already underway. Moss is well placed as a business to build on the success already achieved and I look forward to the challenges ahead of me."

Previous operations director **Simon Hulme** becomes director of human resources.

Lee Glennon has joined Numark Trading Ltd as its marketing manager. He has joined from AAH Pharmaceuticals and has previously held positions at Intersport, Brown Brothers and Aston Manor Brewery. A keen sports enthusiast, Lee supports Birmingham City.

CPL Aromas has appointed **Dominique Preyssas** as executive perfumer, based in Paris.

Swedes take root in Barnstaple

It's that 'work experience' time of year again and Alpharma, the generics manufacturer based in Devon, is going international.

Four Swedish students from the Lindholmen School, Gothenburg, are spending a week shadowing engineers working on Alpharma's manufacturing systems.

Organised in conjunction with the North Devon Further Education College, the students, who are enrolled on an electricity and automation programme, are also making the most of the opportunity to improve their language skills.

Keith Daniels, packing operations manager, says: "We are very happy to play a part in North Devon College's programme by offering work experience to students from abroad."

Eyeing up the competition

The hardened drinkers that make up the *C&D* team are bored with having to drink all the champagne themselves so have decided it's time to give a bottle away.

To coincide with the eyecare feature (*p32*), we'd like you to tell us who these famous pharmacy eyes belong to. The lucky winner of the bubbly will be drawn from all the correct entries received at the office by June 20.

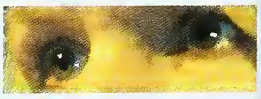
You can write to *C&D* at the Tonbridge address at the front of the magazine or e-mail to *chemdrug@cmpinformation.com*

We'd like to stress that we won't be running a similar competition when it comes to an issue containing a sexual health feature – phew!

So, here goes:

A 

B 

C 

D 

E 

Good, hard fun

You're too late for the fifth annual condom packaging design competition, organised by the Planned Parenthood Western Pennsylvania Action Fund, but perhaps you can start thinking up some ideas for next year.

...'s winner on the theme of ...ents in American

The contest invites condom packets to be designed on a common theme and this year it was Hollywood. The aim is to make condom packs more appealing and consequently a less embarrassing purchase.

Some examples of this year's cinema-based entries include 'Latex Reloaded', 'Gone with the Wind – Rhett's best condom – for those who give a damn' and 'The Casablanca Condom – grab two so he can "play it again"'.

For more information log on to *www.stiffcompetition.org.*

Walking for women

Wellbeing, the charity that funds research into women's health at every stage of their lives, is calling on people to join in one of three five-mile sponsored walks.

The walks are being held at:

- Wollaton Park, Nottingham, June 15
- Battersea Park, London, June 22
- Holyrood Park, Edinburgh September 7.

This year the walks are being supported by Canesten.

If you can't join in one of the walks planned above why not organise your own? Find out more at *www.wellbeing.org.uk*

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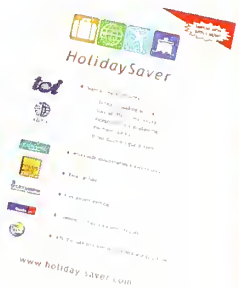

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